Health & Families Council

Tuesday, April 4, 2006
9:00 AM – 10:00 AM
Reed Hall

Meeting Packet

Allan G. Bense
Speaker

Anna Holliday "Holly" Benson
Chair

Council Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Health & Families Council

Start Date and Time:	Tuesday, April 04, 2006 09:00 am
End Date and Time:	Tuesday, April 04, 2006 10:00 am
Location:	Reed Hall (102 HOB)
Duration:	1.00 hrs

Consideration of the following bill(s):

HB 243 Hearing Aid Specialists by Kendrick
HB 329 CS Adult Protective Services by Culp
HB 439 CS Certificates of Birth and Death by Planas
HB 483 Nursing Services by Garcia
HB 587 CS Health Care Practitioners by Galvano
HB 747 CS Health Professionals Treating Speech or Hearing Disorders by Greenstein
HB 947 CS Long-Term Care Coverage by Legg

Pursuant to Rule 7.22(c), amendments by non-appointed members must be filed by 5:00 p.m., Monday, April 3, 2006.

The Chair requests that members of the Council file amendments by 5:00 p.m., Monday, April 3, 2006.

NOTICE FINALIZED on 03/31/2006 15:32 by ISEMINGER.BOBBYE

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 243 Hearing Aid Specialists
SPONSOR(S): Kendrick and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 372

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	11 Y, 0 N	Bell	Mitchell
2) Elder & Long-Term Care Committee	7 Y, 0 N	Walsh	Walsh
3) Health & Families Council		Bell AJB	Moore
4)			
5)			

SUMMARY ANALYSIS

HB 243 excludes licensed hearing aid specialists from the requirement that a certain written statement of a patient's right to refuse or cancel payment, or be reimbursed for payment for other treatment or services, must accompany the advertisement of free, discounted, or reduced fee services.

The bill takes effect July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill removes a regulation that requires hearing aid specialists to make a certain disclosure in their advertisements when advertising services that are free or provided at a discounted or reduced fee.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

In Florida, there are currently 831 licensed hearing aid specialists and 847 licensed audiologists.[1]

Hearing Aid Specialists. Hearing aid specialists are regulated under Part II of Chapter 484, F.S. Generally hearing aid specialists fit and sell hearing amplification systems to individuals in a retail establishment. Some of their duties include conducting hearing tests, interpreting auditory test results, and selecting, fitting, and modifying hearing amplification systems for individuals.

The Department of Health licenses[2] each applicant that the Board of Hearing Aid Specialists certifies:

- Is of good moral character;
- Is 18 years of age;
- Is a graduate of an accredited high school or its equivalent;
- Either:
    - Meets the requirements of the Board of Hearing Aid Specialist training program; or
    - Holds a valid, current license as a hearing aid specialist or its equivalent from another state and has been actively practicing in such capacity for at least 12 months; or
    - Is currently certified by the National Board for Certification in Hearing Instrument Sciences and has been actively practicing for at least 12 months.
- Has passed the licensure examination, which is the International Licensing Examination (ILE) for the Hearing Instrument Dispenser;
- Has demonstrated knowledge of state laws and rules relating to the fitting and dispensing of hearing aids.

Hearing aid specialists are required to complete continuing education requirements as a condition of license renewal.[3]

Audiologists. Audiologists are regulated under Part I of Chapter 468, F.S. The practice of audiology includes the assessment of hearing and balance. Audiologists do research on hearing loss, tinnitus, and balance system dysfunction. Audiologists also select, fit, and dispense amplification systems such as hearing aids; work to prevent hearing loss through providing and fitting protective devices; provide consultation on the effects of noise on hearing; and provide consumer education.

The Department of Health licenses[4] each audiologist applicant that the Board of Speech-Language Pathology and Audiology certifies:

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[1] Source: Florida Department of Health Medical Quality Assurance Licensee Data Center: Hearing Aid Specialist and Audiologist Data Downloads as of February 9, 2006. Figures cited are active licensees only.
[2] S. 484.045(2), F.S.
[3] S. 484.047(4), F.S.
[4] S. 468.1185(2), F.S.

- Holds a Master's degree or is enrolled in a Doctoral degree program from an accredited college or university with a major emphasis in the area of audiology, including completion of 60 semester hours, 30 of which must be at the graduate level;
- Has completed 300 clock hours in supervised clinical practice;
- Has completed nine months of full-time professional employment;
- Has passed the national examination;
- Has completed an education course on HIV/AIDS.[5]

Audiologists are required to complete continuing education requirements biennially as a condition of license renewal.[6]

Federal Regulations. Hearing aid devices are regulated by federal law.[7] Hearing aid specialists and audiologists are required to comply with federal regulations relating to conditions of sale, including:

- Medical evaluation requirements;
- Waiver of the medical evaluation requirements;
- Availability of hearing aid user instructional brochures; and
- Recordkeeping.

State Regulations. In addition to the federal regulations, state law contains specific requirements relating to the sale of hearing aids.

- Thirty Day Trial Period: Both hearing aid specialists and audiologists[8] are required to provide the buyer of a hearing aid with written notice of a 30-day trial period and money back guarantee. The guarantee must permit the purchaser to cancel the purchase for a valid reason.[9] If the hearing aid must be repaired, remade, or adjusted during the 30-day trial period, the running of the 30-day trial period is suspended one day for each 24-hour period that the hearing aid is not in the purchaser's possession. A repaired, remade, or adjusted hearing aid must be claimed by the purchaser within three working days after notification of availability. The running of the 30-day trial period resumes on the day the purchaser reclaims the repaired, remade, or adjusted hearing aid or on the fourth day after notification of availability.
- Itemization of Prices: Hearing aid specialists and audiologists[10] must provide an itemized listing of prices at the request of prospective hearing aid purchasers. This list must provide separate prices for each service component and each product.
- Cancellation by Medical Authorization: Hearing aid purchasers have the right[11] to their money back if a licensed physician, who is board-certified in otolaryngology or internal medicine or who is a licensed family practice physician, certifies in writing that the purchaser has a hearing impairment that contraindicates the use of a hearing aid or that will not be improved by the use of a hearing aid. The purchaser must give notice to the seller via certified mail within 60 days following the date of delivery of the hearing aid in order to effectuate the guarantee.

Economics of Health Care Regulation.[12] Economists argue that the regulation of health care usually involves striking a balance between patient safety and quality of care, and the cost and availability of services. Regulating quality is not without cost, and it is not without an effect on the market for health

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[5] S. 468.1201, F.S.
[6] S. 468.1195, F.S.
[7] *See* 21 C.F.R. 801.420, 21 C.F.R. 801.421
[8] Ss. 484.0512 and 468.1246, F.S., respectively.
[9] A "valid reason" is defined as "failure by the purchaser to achieve satisfaction from use of the hearing aid(s), so long as the hearing aid(s) is returned to the seller within the 30-day trial period in good working condition." *See* Rules 64B6-6.001(2) and 64B30-8.008 (3), F.A.C.
[10] Pursuant to ss. 484.051 and 468.1245, F.S., respectively.
[11] S. 484.0513, F.S., as applies to hearing aid specialists and s. 468.1255, F.S., as applies to audiologists.
[12] This discussion is derived from a presentation to the House Committee on Health Care Regulation by Steve Ullman, Ph.D., University of Miami, on *Health Care Issues Associated with Regulation*, March 2005.

care services. Regulations that increase the cost of providing health care may lead to increased prices, a decrease in quantity, and hurt the bottom line of the supplier of services, thus, limiting access to health care. If regulations increase the costs of health care too much, consumers may drop out of the market. The decrease in demand may then cause a chain reaction so that health care suppliers drop out of the market, which would limit access to health care (the supply). Even a policy aimed at increasing demand for service, may be constrained by regulatory policies that limit the ability for suppliers to respond, so that the effect may be a large increase in price and a smaller increase in quantity of services provided.

Effect of Proposed Bill

As noted, some laws relating to the sale of hearing aids apply equally to hearing aid specialists and to audiologists. However, the following disclosure, required of many professions[13] when advertising services that are free or provided at a discounted or reduced fee ---

> THE PATIENT AND ANY OTHER PERSON RESPONSIBLE FOR PAYMENT HAS A RIGHT TO REFUSE TO PAY, CANCEL PAYMENT, OR BE REIMBURSED FOR PAYMENT FOR ANY OTHER SERVICE, EXAMINATION, OR TREATMENT THAT IS PERFORMED AS A RESULT OF AND WITHIN 72 HOURS OF RESPONDING TO THE ADVERTISEMENT FOR THE FREE, DISCOUNTED FEE, OR REDUCED FEE SERVICE, EXAMINATION, OR TREATMENT.

--- is required to be made by hearing aid specialists, but <u>not</u> by audiologists.

Hearing aid specialists and audiologists often work in close contact with one another, and clinics frequently employ both types of professionals. Although audiologists are licensed to perform many more services than hearing aid specialists, one of an audiologist's primary responsibilities is dispensing of hearing aids. As a practical matter, clinics that employ both hearing aid specialists and audiologists include the disclosure in their advertisements when advertising services that are free or provided at a discounted or reduced fee, even though pursuant to s. 456.062, F.S., such disclosure is not required of audiologists.

HB 243 amends s. 456.062, F.S., to exclude licensed hearing aid specialists from the requirement to publish the disclosure statement with all advertisements of free, discounted, or reduced fee services.

C. SECTION DIRECTORY:

Section 1. Amends s. 456.062, F.S., to exclude licensed hearing aid specialists from having to publish a disclosure statement with all advertisements of free, discounted, or reduced fee services.

Section 2. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[13] Currently 15 other licensed professions, including naturopaths, dentists, and nurses, are required to make the disclosure when advertising services that are free or provided at a reduced or discounted fee. *See* s. 456.062, F.S.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate. HB 243 may lower advertising costs for hearing aid specialists and audiologists who employ hearing aid specialists. Hearing aid specialists and audiologists may choose to pass on their cost savings to customers.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is required to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The Board of Hearing Aid Specialists has stated that audiologists, who also sell hearing aids, are not subject to this same advertising disclosure requirement in s. 456.062, F.S. Placing hearing aid specialists in this category with other health professionals, when they also must offer trial periods, refunds and money back guarantees, may be duplicative or unnecessary.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to hearing aid specialists; amending s. 456.062, F.S.; eliminating the application of certain advertising requirements to health care practitioners licensed under pt. II of ch. 484, F.S., relating to the regulation of hearing aid specialists; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 456.062, Florida Statutes, is amended to read:

456.062 Advertisement by a health care practitioner of free or discounted services; required statement.--In any advertisement for a free, discounted fee, or reduced fee service, examination, or treatment by a health care practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, chapter 467, chapter 478, chapter 483, part I of chapter 484, chapter 486, chapter 490, or chapter 491, the following statement shall appear in capital letters clearly distinguishable from the rest of the text: THE PATIENT AND ANY OTHER PERSON RESPONSIBLE FOR PAYMENT HAS A RIGHT TO REFUSE TO PAY, CANCEL PAYMENT, OR BE REIMBURSED FOR PAYMENT FOR ANY OTHER SERVICE, EXAMINATION, OR TREATMENT THAT IS PERFORMED AS A RESULT OF AND WITHIN 72 HOURS OF RESPONDING TO THE ADVERTISEMENT FOR THE FREE, DISCOUNTED FEE, OR REDUCED FEE SERVICE, EXAMINATION, OR TREATMENT. However, the required statement shall not be

necessary as an accompaniment to an advertisement of a licensed health care practitioner defined by this section if the advertisement appears in a classified directory the primary purpose of which is to provide products and services at free, reduced, or discounted prices to consumers and in which the statement prominently appears in at least one place.

Section 2. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 329 CS Adult Protective Services
SPONSOR(S): Culp; Gibson, H.; Sobel
TIED BILLS: None **IDEN./SIM. BILLS:** CS/SB 1182

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder & Long-Term Care Committee	7 Y, 0 N, w/CS	DePalma	Walsh
2) Civil Justice Committee	6 Y, 0 N, w/CS	Blalock	Bond
3) Health Care Appropriations Committee	15 Y, 0 N	Ekholm	Massengale
4) Health & Families Council		DePalma	Moore
5)			

SUMMARY ANALYSIS

Chapter 415, F.S., establishes a program of protective services for all disabled adults or elderly persons in need of such services. This bill amends the Adult Protective Services Act to allow the Department of Children and Family Services explicit authority to protect individuals from the effects of self-neglect by redefining the term "neglect", and by redefining the term "abuse" to include abuse by a relative or household member.

This bill further amends Chapter 415, F.S., by including the Agency for Persons with Disabilities among the list of departmental agencies, employees, and agents with access to all records concerning reports of abuse, neglect, or exploitation of a vulnerable adult, including all reports made to the central abuse hotline, and all records generated as a result of such reports.

The bill appears to have a minimal fiscal impact on state government, and does not appear to have a fiscal impact on local governments.

The bill will be effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government—This bill increases the Department of Children and Family Services' (DCF) responsibility in carrying out the provisions of the Adult Protective Services Act by giving the department explicit authority to protect individuals from the effects of self-neglect and to investigate alleged abuse of vulnerable adults by relatives and household members who do not serve as a caregiver to such individuals.

Safeguard individual liberty—This bill authorizes protective services where there are reports of alleged self-neglect by a vulnerable adult.

Empower families—This bill grants DCF the ability to provide protective services where a relative has abused or neglected a vulnerable adult, even in the absence of a caregiver relationship.

B. EFFECT OF PROPOSED CHANGES:

Background—Abuse and Neglect of Vulnerable Adults

The Legislature recognizes that there are many persons in this state who, because of age or disability, are in need of protective services.[1] Chapter 415, F.S., the Adult Protective Services Act, provides statutory authority for the Department of Children and Family Services (DCF) to investigate reports of abuse, neglect, or exploitation of a vulnerable adult.[2]

The Adult Protective Services program is a system of specialized social services directed toward protecting vulnerable adults who are unable to prevent further instances of abuse, neglect or exploitation. The department sends staff to make an assessment of an individual's need for protective services after a reported allegation of abuse, neglect or exploitation is received by the Abuse Hotline. Adult Protective Services includes the following four basic elements:

1. the on-site investigation of all reports of alleged abuse, neglect, or exploitation;
2. a determination of immediate risk to the vulnerable adult and the provision of necessary emergency services;
3. an evaluation of the need for ongoing protective supervision; and
4. provision or arrangement of ongoing protective services.

Effect of the Bill -- Abuse and Neglect of Vulnerable Adults

Besides the potential for being neglected by a caregiver, the potential exists for a vulnerable adult to neglect themselves because of either their age or disability. In Fiscal Year 2003-2004, DCF investigated 6,394 cases reported to the Florida Abuse Hotline that were verified or contained some indications of self-neglect (other than medical neglect).[3] Of these self-neglect cases, more than 40 percent involved persons 80 years of age and older. However, the current statutory definition of

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[1] Section 415.101(2), F.S.

[2] Per s. 415.102(26), F.S., a "vulnerable adult" is a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.

[3] *Adult Protective Services Annual Report Fiscal Year 2003-2004*, Table F-6, Demographic Characteristics of Victims by Verified and Some Indication Maltreatments, Self-Neglect In Need of Services, Department of Children and Family Services, March 2005.

"neglect"[4] does not include neglect caused by a vulnerable adult, and the department's authority to provide services upon occurrence of self-neglect has been questioned by the courts.[5]

This bill adds "vulnerable adult" to the definition of "neglect" found in s. 415.102(15), F.S., and adds "vulnerable adult in need of services"[6] to s. 415.1051(1), F.S., relating to non-emergency protective services. These changes give DCF explicit authority to provide voluntary services or petition the court for involuntary non-emergency services and protective supervision when an investigation determines that a vulnerable adult is neglecting himself or herself.

The Adult Protective Services Act defines "abuse"[7] in terms of willful acts committed or threatened by a "caregiver" that causes or is likely to cause impairment to a vulnerable adult's well-being. The statutory definition of "caregiver" found in chapter 415, F.S., includes as a caregiver a person entrusted with the responsibility for the frequent and regular care of a vulnerable adult, and who has an agreement or understanding with that person or that person's guardian that a caregiver role exists.[8] Although the definition notes that a caregiver may include "relatives, household members, guardians, neighbors, and employees and volunteers of facilities ..." either an explicit or implicit caregiver relationship must be present for DCF to accept and investigate a report of abuse.[9]

During the 2000 Legislative session, s. 415.102(1), F.S., was amended to omit the requirement that a relationship exist between a vulnerable adult and the individual alleged to have committed acts or omissions evidencing abuse. Subsequently, in 2003, the Legislature again amended the Adult Protective Services Act to require the presence of a caregiver relationship before DCF could accept and investigate alleged abuse maltreatments.

This bill amends the definition of "abuse" in s. 415.102(1), F.S., to include willful or threatened acts committed by a relative or household member which cause, or are likely to cause, significant impairment to a vulnerable adult's health. This change allows DCF to accept and investigate the alleged abuse of vulnerable adults by relatives and household members who are neither explicit nor implicit caregivers of such vulnerable adult.

Background—Access to Reports and Records of Abuse, Neglect, or Exploitation of Vulnerable Adults

Pursuant to s. 415.103, F.S., DCF maintains a central abuse hotline, enabling the department to perform the following:

- accept reports for investigation when there is a reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited;
- determine whether the allegations made by the reporter require an immediate, 24-hour, or next-working-day response priority;

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[4] Per s. 415.102(15), F.S., "neglect" is defined as "the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of a vulnerable adult. The term "neglect" also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death."

[5] *Florida Department of Children and Family Services v. McKim,* 869 So.2d 760, (Fla. 1st DCA 2004) (fact that allegedly vulnerable adult was suffering from results of self-neglect did not support order under Adult Protective Services Act of protective services, where definition of "neglect" required that neglect have occurred at hand of caregiver and statutory definition of "vulnerable adult" did not include concept of self-neglect.)

[6] Per s. 415.102(27), F.S., a "vulnerable adult in need of services" means a vulnerable adult who has been determined by a protective investigator to be suffering from the ill effects of neglect not caused by a second party perpetrator and is in need of protective services or other services to prevent further harm. S. 415.102(27), F.S.

[7] S. 415.102(1), F.S.

[8] S. 415.102(4), F.S.

[9] *Ibid.*

- when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might better resolve the reporter's concerns;
- immediately identify and locate prior reports of abuse, neglect, or exploitation;
- track critical steps in the investigative process to ensure compliance with all requirements for all reports;
- maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation; and
- serve as a resource for the evaluation, management, and planning of preventive and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation.

The Adult Protective Services Act imposes a mandatory reporting requirement on any person who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected or exploited.[10] In addition, the Act imposes a reporting requirement on any person who is required to investigate such reports, where there is a reasonable cause to suspect that a vulnerable adult died as a result of abuse, neglect or exploitation. In such instances, these individuals are required to immediately report their suspicion to the appropriate medical examiner, criminal justice agency, and to DCF.[11]

Current law provides that all records concerning reports of abuse, neglect, or exploitation of the vulnerable adult, including reports made to the central abuse hotline, are confidential and exempt from the public records statutes, unless release of the record is specifically authorized in chapter 415, F.S.[12] Section 415.107(3)(a), F.S., provides that access to all records, except the name of the individual filing a report, shall be granted to employees or agents of DCF, the Agency for Health Care Administration, or the Department of Elderly Affairs who are responsible for:

- protective investigations;
- ongoing protective services; and
- licensure approval of nursing homes, assisted living facilities, adult day care centers, adult family-care homes, home care for the elderly, hospices, or other facilities used for the placement of vulnerable adults.

In October 2004, the Agency for Persons with Disabilities (APD) became an agency separate from the Department of Children and Family Services, specifically tasked with serving the needs of persons with developmental disabilities[13] and licensing facilities that provide care and services to the disabled. Prior to that time, it existed as the Developmental Disabilities Program within DCF. The Agency for Persons with Disabilities works in partnership with local communities to ensure the safety, well-being and self-sufficiency of more than 32,000 persons with developmental disabilities throughout Florida. The agency provides assistance to identify the needs of people with developmental disabilities, as well as the necessary funding to purchase supports and services. Since APD is now its own agency and no longer a part of DCF, APD does not have access to abuse reports and records as it did when it was under DCF.

Effect of Bill—Access to Reports and Records of Abuse, Neglect, or Exploitation of Vulnerable Adults

This bill inserts APD into the list of agencies, departments, employees, and agents contained in s. 415.107(3)(a), F.S., with access to records and reports of the Adult Protective Services. Therefore, under this bill, employees and agents of APD who are responsible for carrying out protective investigations, ongoing protective services, or licensure of facilities used for the placement of

[10] Section 415.1034(1)(a), F.S.
[11] Section 415.1034(2), F.S.
[12] Section 415.107, F.S.
[13] Per s. 393.063(10), F.S., a "developmental disability" is a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

vulnerable adults would have access to all records and reports of abuse, neglect, or exploitation of a vulnerable adult.

This bill also amends section 415.107(3)(h), Florida Statutes, to provide access to abuse records for APD officials responsible for the following:

- administration or supervision of programs for the prevention, investigation, or treatment of abuse, neglect, or exploitation of vulnerable adults; and
- taking administrative action concerning an employee alleged to have abused, neglected, or exploited a vulnerable adult in an institution.

C. SECTION DIRECTORY:

Section 1. Amends s. 415.102, F.S., adding abuse committed by a relative or household member to the definition of "abuse" and modifying the definition of "neglect" to include the concept of self-neglect.

Section 2. Amends s. 415.1051(1), F. S., authorizing the department to petition the court for non-emergency protective services interventions where the department has reasonable cause to believe that a vulnerable adult in need of services is being abused, neglected, or exploited, and is in need of protective services but lacks the capacity to consent to protective services.

Section 3. Amends s. 415.107(3)(a) and (h), F.S., including the APD among the list of agencies, departments, employees, and agents able to access Adult Protective Services records and reports.

Section 4. Provides that the act is effective upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DCF anticipates that this bill will have a minimal fiscal impact on the department, which it states can be absorbed within existing departmental resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

For Fiscal Year 2006-2007, DCF has requested, and the Governor has recommended, $10.5 million and 87 positions for an adult protective investigations workload increase.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

At its January 11, 2006 meeting, the Committee on Elder & Long-Term Care adopted an amendment to House Bill 329 CS. The amendment does the following:

- adds APD to the list of agencies, departments, employees and agents bestowed with access to all Adult Protective Services records for the purpose of carrying out protective investigations, ongoing protective services, or licensure and approval of certain nursing facilities;

- enables information collected from the central abuse hotline to be used for employment screening in the instances contemplated pursuant to subsections 415.107(3)(a) and (h), F.S.; and

- allows such information, and information collected from the automated abuse information system, to be used by the Department of Children and Family Services and its agents and contract providers, the Agency for Persons with Disabilities, the Agency for Health Care Administration, the Department of Elderly Affairs, the Department of Health and county agencies for licensure and approval of certain nursing facilities.

The Committee favorably reported a Committee Substitute.

On February 22, 2006, the Civil Justice Committee adopted one amendment to this bill.

- The amendment removes language that would have enabled unfounded allegations of abuse, neglect, and exploitation contained in the central abuse hotline to be used for employment screening or in the licensure or approval process for facilities that care for the elderly or disabled, which was inconsistent with chapter 2005-173 Laws of Florida. (That law amended section 39.301, Florida Statutes, and provides that when an investigation is closed and a person is not identified as a caregiver responsible for the abuse, neglect, or abandonment alleged in the report, then information contained in a report of abuse, neglect, or exploitation cannot be used for the purpose of employment screening or licensing).

- The amendment grants access to abuse records for APD officials responsible for administration of abuse prevention, investigation, or treatment programs, or handling employees alleged to have abused, neglected, or exploited a vulnerable adult at an institution.

- The amendment also makes grammatical changes in the bill that conform to the wording found in the companion bill, CS/SB 1182.

The bill was then reported favorably with a committee substitute.

CHAMBER ACTION

The Civil Justice Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to adult protective services; amending s. 415.102, F.S.; redefining the term "abuse" to include actions by a relative or a household member which are likely to harm a vulnerable adult; redefining the term "neglect" to include actions of a vulnerable adult against himself or herself; amending s. 415.1051, F.S.; providing for the Department of Children and Family Services to petition the court for an order authorizing the provision of protective services for a vulnerable adult in need of services; amending s. 415.107, F.S.; authorizing the Agency for Persons with Disabilities to have access to certain otherwise confidential records and reports; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (1) and (15) of section 415.102, Florida Statutes, are amended to read:

415.102 Definitions of terms used in ss. 415.101-415.113.--As used in ss. 415.101-415.113, the term:

(1) "Abuse" means any willful act or threatened act by a relative, caregiver, or household member which ~~that~~ causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health. Abuse includes acts and omissions.

(15) "Neglect" means the failure or omission on the part of the caregiver or vulnerable adult to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, which ~~that~~ a prudent person would consider essential for the well-being of a vulnerable adult. The term "neglect" also means the failure of a caregiver or vulnerable adult to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death.

Section 2. Subsection (1) of section 415.1051, Florida Statutes, is amended to read:

415.1051 Protective services interventions when capacity to consent is lacking; nonemergencies; emergencies; orders; limitations.--

(1) NONEMERGENCY PROTECTIVE SERVICES INTERVENTIONS.--If the department has reasonable cause to believe that a vulnerable adult or a vulnerable adult in need of services is being abused,

neglected, or exploited and is in need of protective services but lacks the capacity to consent to protective services, the department shall petition the court for an order authorizing the provision of protective services.

(a) Nonemergency protective services petition.--The petition must state the name, age, and address of the vulnerable adult, allege specific facts sufficient to show that the vulnerable adult is in need of protective services and lacks the capacity to consent to them, and indicate the services needed.

(b) Notice.--Notice of the filing of the petition and a copy of the petition must be given to the vulnerable adult, to that person's spouse, guardian, and legal counsel, and, when known, to the adult children or next of kin of the vulnerable adult. Such notice must be given at least 5 days before the hearing.

(c) Hearing.--

1. The court shall set the case for hearing within 14 days after the filing of the petition. The vulnerable adult and any person given notice of the filing of the petition have the right to be present at the hearing. The department must make reasonable efforts to ensure the presence of the vulnerable adult at the hearing.

2. The vulnerable adult has the right to be represented by legal counsel at the hearing. The court shall appoint legal counsel to represent a vulnerable adult who is without legal representation.

3. The court shall determine whether:

a. Protective services, including in-home services, are necessary.

b. The vulnerable adult lacks the capacity to consent to the provision of such services.

(d) Hearing findings.--If at the hearing the court finds by clear and convincing evidence that the vulnerable adult is in need of protective services and lacks the capacity to consent, the court may issue an order authorizing the provision of protective services. If an order for protective services is issued, it must include a statement of the services to be provided and designate an individual or agency to be responsible for performing or obtaining the essential services on behalf of the vulnerable adult or otherwise consenting to protective services on behalf of the vulnerable adult.

(e) Continued protective services.--

1. No more than 60 days after the date of the order authorizing the provision of protective services, the department shall petition the court to determine whether:

a. Protective services will be continued with the consent of the vulnerable adult pursuant to subsection (1);

b. Protective services will be continued for the vulnerable adult who lacks capacity;

c. Protective services will be discontinued; or

d. A petition for guardianship should be filed pursuant to chapter 744.

2. If the court determines that a petition for guardianship should be filed pursuant to chapter 744, the court,

for good cause shown, may order continued protective services until it makes a determination regarding capacity.

(f) Costs.--The costs of services ordered under this section must be paid by the perpetrator if the perpetrator is financially able to do so; or by third-party reimbursement, if available. If the vulnerable adult is unable to pay for guardianship, application may be made to the public guardian for public guardianship services, if available.

Section 3. Paragraphs (a) and (h) of subsection (3) of section 415.107, Florida Statutes, are amended to read:

415.107 Confidentiality of reports and records.--

(3) Access to all records, excluding the name of the reporter which shall be released only as provided in subsection (6), shall be granted only to the following persons, officials, and agencies:

(a) Employees or agents of the department, ~~of~~ the Agency for Health Care Administration, the Agency for Persons with Disabilities, or ~~of~~ the Department of Elderly Affairs who are responsible for carrying out protective investigations, ongoing protective services, or licensure or approval of nursing homes, assisted living facilities, adult day care centers, adult family-care homes, home care for the elderly, hospices, or other facilities used for the placement of vulnerable adults.

(h) Any appropriate official of the department, ~~of~~ the Agency for Health Care Administration, the Agency for Persons with Disabilities, or ~~of~~ the Department of Elderly Affairs who is responsible for:

1. Administration or supervision of the programs for the prevention, investigation, or treatment of abuse, neglect, or exploitation of vulnerable adults when carrying out an official function; or

2. Taking appropriate administrative action concerning an employee alleged to have perpetrated abuse, neglect, or exploitation of a vulnerable adult in an institution.

Section 4. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 439 CS Certificates of Birth and Death
SPONSOR(S): Planas and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 746

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 0 N, w/CS	Bell	Mitchell
2) Governmental Operations Committee	5 Y, 0 N, w/CS	Mitchell	Williamson
3) Health Care Appropriations Committee	13 Y, 0 N, w/CS	Money	Massengale
4) Health & Families Council		Bell AJB	Moore
5)			

SUMMARY ANALYSIS

HB 439 CS creates a stillbirth registration which allows the parents of a stillborn child to obtain an optional "certificate of birth resulting in stillbirth."

Stillbirths occur in nearly 1 out of every 200 pregnancies. Estimates range from 25,000 to 39,000 stillbirths annually in the U.S. It is difficult to estimate an accurate count because national and state rates for "infant mortality" do not include stillborns. In the last 10 years there has been a nationwide movement to increase the awareness of stillbirths and increase research.

The bill provides the information to be given to the parents of a stillborn child; the requirements for requesting the certificate of birth resulting in stillbirth; and the contents of the certificate of birth resulting in stillbirth.

The bill also provides for electronic receipt of birth, death, and fetal death certificates.

The bill authorizes DOH to charge a fee of not less than $3 or more than $5 for processing and filing a new certificate of birth resulting in stillbirth. The nonrecurring fiscal impact on state government expenditures is estimated at $4,700 for forms and computer system modifications. The fiscal impact on state government revenues is projected to be in a range from $201 to $335 in the first year and in a range from $300 to $500 in the second and following years.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government - The bill creates a "certificate of birth resulting in stillbirth." The certificate of birth resulting in stillbirth is optional and is in addition to the certificate of fetal death. The bill increases the rulemaking authority of the Department of Health.

Empower Families - The bill creates a "certificate of birth resulting in stillbirth." The certificate of birth resulting in stillbirth is optional and is in addition to the certificate of fetal death.

B. EFFECT OF PROPOSED CHANGES:

Vital Records: Births, Deaths, and Fetal Deaths

The Florida Vital Statistics Act[1] authorizes the Department of Health to establish an Office of Vital Statistics, which is responsible for the uniform and efficient registration, compilation, storage, and preservation of all vital records[2] in Florida, including births and fetal deaths.[3] It also permits the Department of Health to appoint a state registrar of vital statistics for each registration district in the state.[4]

Section 382.031, Florida Statutes, sets forth the requirements for certificates of births for live births.[5] Section 382.008, Florida Statutes, sets forth the requirements for certificates of death and fetal death.[6] This bill amends these sections to authorize the state registrar to receive certificates of birth, death, and fetal death through facsimile or other electronic means. The electronic receipt is permitted for all required birth, death, and fetal death filings and constitutes the required delivery.

Vital Records: Stillbirths

There currently is no separate definition, category, or certificate for a stillbirth,[7] which is "an unintended, intrauterine fetal death after a gestational age of not less than 20 completed weeks."[8] This bill creates a definition of stillbirth[9] and creates section 382.0085, Florida Statutes, to provide for a "stillbirth registration."

The bill requires the Department of Health to issue a certificate of birth resulting in stillbirth within 60 days after the request of a parent named on a fetal death certificate and allows a parent to request a

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[1] Fla. Stat. § 382.001 (2005) (provides that chapter 382, Florida Statutes, is the Florida Vital Statistics Act).
[2] Fla. Stat. § 382.002(13) (2005) (vital records include certificates or reports of birth, death, fetal death, marriage, dissolution of marriage (divorce), and name changes).
[3] Fla. Stat. § 382.003 (2005).
[4] *Id.*
[5] Fla. Stat. § 382.002(9) (2005) ("the complete expulsion or extraction of a product of human conception from its mother, irrespective of the duration of pregnancy, which, after such expulsion, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, and definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached").
[6] Fla. Stat. § 382.002(5) (2005) ("death prior to the complete expulsion or extraction of a product of human conception from its mother if the 20th week of gestation has been reached and the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles").
[7] Stillbirths are recorded as fetal deaths. In 2004, there were 1,701 fetal deaths of 20 or more weeks gestation (stillbirths). Fla. Dept. of Health, *Florida Vital Statistics Annual Report*, Table F-1 (2004), available at http://www.flpublichealth.com/VSBOOK/VSBOOK.aspx?CEID=570 &Year=2004 (last visited Mar. 6, 2006).
[8] Fla. HB 439 CS (2005).
[9] The bill creates a new definition in section 382.002(14), Florida Statutes.

certificate of birth resulting in stillbirth regardless of the date on which the certificate of fetal death was issued. Under the proposed legislation stillborns would still be classified as a fetal death, but the parents would have the option of requesting a certificate of birth resulting in stillbirth.

The bill prohibits the stillbirth registration provisions, or the definition of stillbirth, from being used to "establish, bring, or support a civil cause of action seeking damages against any person or entity for bodily injury, personal injury, or wrongful death for a stillbirth."

The bill provides that the certificate of birth resulting in stillbirth is a public record.

How to Obtain a Certificate of Birth resulting in Stillbirth

The bill directs the person who is required to file a fetal death certificate to advise the parent of a stillborn child:

- That the parent may request the preparation of a certificate of birth resulting in stillbirth in addition to the fetal death certificate;
- That the parent may obtain a certificate of birth resulting in stillbirth by contacting the Office of Vital Statistics;
- How the parent may contact the Office of Vital Statistics to request a certificate of birth resulting in stillbirth; and
- That a copy of the original certificate of birth resulting in stillbirth is a document that is available as a public record when held by an agency as defined under section 119.011(2), Florida Statutes.

The bill also requires the Office of Vital Statistics to make the public records disclosure to the parents.

The bill provides that the request for a certificate of birth resulting in stillbirth must be on a form designated by the department. The request must include the date of the stillbirth and the county in which the stillbirth occurred. In addition, the state file number from the fetal death report must be provided.

Requirements for the Certificate of Birth Resulting in Stillbirth

The bill requires the certificate of birth resulting in stillbirth to contain the date of the stillbirth, the name of the county in which the stillbirth occurred, the name of the stillborn child, the state file number of the corresponding certificate of fetal death, and a notification.[10] The name of the stillborn child must be the same as that provided on the original or amended certificate of the fetal death report.[11] If there is no name on the original or amended fetal death certificate and the requesting parent does not wish to provide a name, the bill requires the Office of Vital Statistics to fill in the certificate of birth resulting in stillbirth with the name "baby boy" or "baby girl" and the last name of the parents.[12]

Administration Authority

The bill authorizes the Department of Health to adopt rules regarding the form, content, and process for the certificate of birth resulting in stillbirth. The bill also provides that it is final agency action, which is not subject to review under chapter 120, Florida Statutes, for the Office of Vital Statistics to refuse to issue a certificate to a person who is not a parent named on the fetal death certificate and who is not entitled to a certificate of birth resulting in stillbirth.

The bill authorizes the Department of Health to charge a fee of not less than $3 or more than $5 for processing and filing a new certificate of birth resulting in stillbirth.

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[10] The certificate of birth resulting in stillbirth must contain the following statement: "This certificate is not proof of live birth."
[11] Fla. Stat. § 382.008 (2005).
[12] Fla. Stat. § 382.013 (2005) (provides for the naming of a child).

BACKGROUND

Stillbirth

When fetal death occurs after 20 weeks of pregnancy, it is referred to as stillbirth. Over the last 20 years, stillbirths have declined by nearly 50 percent. This is largely due to better treatment of certain conditions, such as maternal high blood pressure and diabetes, which can increase the risk of stillbirth. Rh disease,[13] which until 1960s was an important cause of stillbirth, can now usually be prevented.

However, stillbirths still occur in nearly 1 out of every 200 pregnancies.[14] Estimates range from 25,000 to 39,000 stillbirths annually in the U.S. It is difficult to estimate an accurate count because national and state rates for "infant mortality" do not include stillborns. In the last 10 years there has been a national movement to increase the awareness of stillbirths and increase research. To support more research The National Institute of Child Health and Human Development (NICHD) created the initiative, *Research on the Scope and Causes of Stillbirth in the United States*. The NICHD project developed a network of research sites the sole purpose of which is to understand stillbirth.

Up to half of all stillbirths occur in pregnancies that seem problem-free. While 14 percent of fetal deaths occur during labor and delivery, 86 percent occur before labor begins. The pregnant woman may suspect something is wrong if the baby suddenly stops moving around and kicking. The most common causes of stillbirth include: placental problems, birth defects, growth restrictions, and infections. In more than one-third of cases the cause of stillbirth cannot be determined.

Stillbirth Policy Trends

Currently there is a national movement to recognize the birth of stillborn children. Thirteen states have passed legislation that creates a "Certificate of Birth Resulting in Stillbirth." Another nine states passed laws to create a "Certificate of Stillbirth." Stillborn awareness advocates prefer the former Certificate because it recognizes that a birth has taken place.[15]

C. SECTION DIRECTORY:

Section 1. - Amends section 382.002, Florida Statutes, providing definitions.

Section 2. - Amends section 382.008, Florida Statutes, authorizing the electronic receipt of death or fetal death certificates.

Section 3. - Creates section 382.0085, Florida Statutes, providing for stillbirth registration, a certificate of birth resulting in stillbirth, and related requirements.

Section 4. - Amends section 382.013, Florida Statutes, authorizing the electronic receipt of birth certificates.

Section 5. - Amends section 382.0255, Florida Statutes, specifying a fee.

Section 6. - Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[13] Rh disease is the incompatibility between the blood of the mother and baby. It is treated by giving an Rh-negative woman an injection of immune globulin at 28 weeks of pregnancy, and again after the birth of an Rh-positive baby.
[14] National Institute of Health, Stillbirth Facts, http://nichd.nih.gov/womenshealth/miscarriage.cfm
[15] Missing Angels Foundation, legislation state chart, http://www.missfoundation.org.

1. Revenues:

   The bill authorizes the Department of Health to set a fee of $3-$5 for the certificate of birth resulting in stillbirth. If the fee is set at $3, the estimated revenue would be $201 in year one, and $300 in year two. If the fee is set at $5, the estimated revenue would be $335 in year one, and $500 in year two.

2. Expenditures:

   The Department of Health estimates a $4,700 first-year, nonrecurring fiscal impact on state government: $1,200 for form design/printing costs and $3,500 for computer system modifications.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   This bill does not appear to create, modify, amend, or eliminate revenues of local governments.

2. Expenditures:

   This bill does not appear to create, modify, amend, or eliminate expenditures of local governments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The Office of Vital Statistics is authorized to charge a fee for a certificate of birth resulting in stillbirth.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not appear to reduce the percentage of state tax shared with counties or municipalities. This bill does not appear reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill authorizes the Department of Health to adopt rules regarding the form, content, and process for the certificate of birth resulting in stillbirth.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On February 22, 2006 the Health Care Regulation Committee adopted three amendments.

Amendment 1: Specified that a Certificate of Birth Resulting in Stillbirth is a public record.

Amendment 2: Removed a time constraint on the Department of Health development of the form and content of the Certificate of Birth Resulting in Stillbirth by rule.
Amendment 3: Requires the Office of Vital Statistics to inform any patient that requests a Certificate of Birth Resulting in Stillbirth that the document is an official public record.

On March 8, 2006, the Governmental Operations Committee adopted two amendments:

- **Amendment 1** - Revised and reorganized provisions related to stillbirth registration.

- Specifically authorizes parents of a stillborn child to receive a certificate of birth resulting in stillbirth.
- Continues to require certain notifications to parents by the person who files the fetal death certificate.
- Sets forth requirements for the request of a certificate of birth resulting in stillbirth.
- Details required elements of the certificate of birth resulting in stillbirth.
- Provides that the certificate of birth resulting in stillbirth is a public record and continues to require notification by the Office of Vital Statistics.
- Revises the applicable rulemaking authority of the Department of Health.

- **Amendment 2** - Expands the scope of the bill to permit the electronic receipt of certificates of birth, death, or fetal death.

The Governmental Operations Committee reported the bill favorably with committee substitute.

On March 20, 2006, the Health Care Appropriations Committee adopted a technical amendment that changed all references of local registrar to state registrar. The committee reported the bill favorably with committee substitute.

The analysis is drafted to the committee substitute.

CHAMBER ACTION

The Health Care Appropriations Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to certificates of birth and death; amending s. 382.002, F.S.; providing definitions; amending s. 382.008, F.S.; authorizing the State Registrar of the Office of Vital Statistics of the Department of Health to receive electronically the certificate of death or fetal death which is required to be filed with the local registrar; creating s. 382.0085, F.S.; requiring the Department of Health to issue a certificate of birth resulting in stillbirth upon request of a specified parent; requiring that the person required to file the fetal death certificate advise a parent of a stillborn child about the availability of a certificate of birth resulting in stillbirth; requiring that the person required to file the fetal death certificate inform a parent of a stillborn child that copies of the birth certificate resulting in stillbirth may be available as a public record; requiring the form prescribed by the

department by rule to contain specified information; designating the certificate of birth resulting in stillbirth as a public record; authorizing a parent to request a certificate of birth resulting in stillbirth without regard to the date on which the certificate of fetal death was issued; designating the refusal to issue a certificate of birth resulting in stillbirth to certain persons as final agency action not subject to administrative review; prohibiting the use of certificates of birth resulting in stillbirth to calculate live birth statistics; requiring rulemaking by the department for the certificate of birth resulting in stillbirth; prohibiting specified provisions of law from being used in certain civil actions; amending s. 382.013, F.S.; authorizing the State Registrar of the Office of Vital Statistics of the Department of Health to receive electronically the birth certificate for each live birth that is required to be filed with the local registrar; amending s. 382.0255, F.S.; authorizing the Department of Health to collect fees for a certificate of birth resulting in stillbirth; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 382.002, Florida Statutes, is amended to read:

382.002 Definitions.--As used in this chapter, the term:

(1) "Certificate of birth resulting in stillbirth" means a certificate issued to record the birth of a stillborn child.

(2) ~~(1)~~ "Certification" or "certified" means a document containing all or a part of the exact information contained on the original vital record, and which, when issued by the State Registrar, has the full force and effect of the original vital record.

(3) ~~(2)~~ "Dead body" means a human body or such parts of a human body from the condition of which it reasonably may be concluded that death recently occurred.

(4) ~~(3)~~ "Department" means the Department of Health.

(5) ~~(4)~~ "Dissolution of marriage" includes an annulment of marriage.

(6) ~~(5)~~ "Fetal death" means death prior to the complete expulsion or extraction of a product of human conception from its mother if the 20th week of gestation has been reached and the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

(7) ~~(6)~~ "Final disposition" means the burial, interment, cremation, removal from the state, or other authorized disposition of a dead body or a fetus as described in subsection (6) ~~(5)~~. In the case of cremation, dispersion of ashes or cremation residue is considered to occur after final disposition; the cremation itself is considered final disposition.

(8) ~~(7)~~ "Funeral director" means a licensed funeral director or direct disposer licensed pursuant to chapter 497 or other person who first assumes custody of or effects the final disposition of a dead body or a fetus as described in subsection (6) ~~(5)~~.

(9) ~~(8)~~ "Legal age" means a person who is not a minor, or a minor who has had the disability of nonage removed as provided under chapter 743.

(10) ~~(9)~~ "Live birth" means the complete expulsion or extraction of a product of human conception from its mother, irrespective of the duration of pregnancy, which, after such expulsion, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, and definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

(11) ~~(10)~~ "Medical examiner" means a person appointed pursuant to chapter 406.

(12) ~~(11)~~ "Physician" means a person authorized to practice medicine, osteopathic medicine, or chiropractic medicine pursuant to chapter 458, chapter 459, or chapter 460.

(13) ~~(12)~~ "Registrant" means the child entered on a birth certificate, the deceased entered on a death certificate, and the husband or wife entered on a marriage or dissolution of marriage record.

(14) "Stillbirth" means an unintended, intrauterine fetal death after a gestational age of not less than 20 completed weeks.

(15) ~~(13)~~ "Vital records" or "records" means certificates or reports of birth, death, fetal death, marriage, dissolution of marriage, name change filed pursuant to s. 68.07, and data related thereto.

(16) ~~(14)~~ "Vital statistics" means a system of registration, collection, preservation, amendment, and certification of vital records, the collection of other reports required by this act, and activities related thereto, including the tabulation, analysis, and publication of data obtained from vital records.

Section 2. Subsection (2) of section 382.008, Florida Statutes, is amended to read:

382.008 Death and fetal death registration.--

(2)(a) The funeral director who first assumes custody of a dead body or fetus shall file the certificate of death or fetal death. In the absence of the funeral director, the physician or other person in attendance at or after the death shall file the certificate of death or fetal death. The person who files the certificate shall obtain personal data from the next of kin or the best qualified person or source available. The medical certification of cause of death shall be furnished to the funeral director, either in person or via certified mail, by the physician or medical examiner responsible for furnishing such information. For fetal deaths, the physician, midwife, or hospital administrator shall provide any medical or health information to the funeral director within 72 hours after expulsion or extraction.

(b) The State Registrar may receive electronically a certificate of death or fetal death which is required to be filed with the local registrar under this chapter through facsimile or other electronic transfer for the purpose of filing the certificate. The receipt of a certificate of death or fetal death by electronic transfer constitutes delivery to the State Registrar as required by law.

Section 3. Section 382.0085, Florida Statutes, is created to read:

382.0085 Stillbirth registration.--

(1) For any stillborn child in this state, the department shall issue a certificate of birth resulting in stillbirth within 60 days after a parent named on a fetal death certificate submits a request for a certificate of birth resulting in stillbirth.

(2) The person who is required to file a fetal death certificate under this chapter shall advise the parent of a stillborn child:

(a) That the parent may request the preparation of a certificate of birth resulting in stillbirth in addition to the fetal death certificate.

(b) That the parent may obtain a certificate of birth resulting in stillbirth by contacting the Office of Vital Statistics.

(c) How the parent may contact the Office of Vital Statistics to request a certificate of birth resulting in stillbirth.

(d) That a copy of the original certificate of birth resulting in stillbirth is a document that is available as a public record when held by an agency as defined under s. 119.011(2).

(3) The request for a certificate of birth resulting in stillbirth shall be on a form prescribed by the department by rule and must include the date of the stillbirth and the county in which the stillbirth occurred. The request form shall include a space for the parent requesting the certificate of birth resulting in stillbirth to fill in the state file number of the corresponding certificate of fetal death pursuant to s. 382.008, if known.

(4) The certificate of birth resulting in stillbirth shall contain:

(a) The date of the stillbirth.

(b) The county in which the stillbirth occurred.

(c) The name of the stillborn child as provided on the original or amended certificate of fetal death pursuant to s. 382.008. If a name does not appear on the original or amended certificate of fetal death and the requesting parent does not wish to provide a name, the Office of Vital Statistics shall fill in the certificate of birth resulting in stillbirth with the name "baby boy" or "baby girl" and the last name of the parents as provided in s. 382.013(3).

(d) The state file number of the corresponding certificate of fetal death.

(e) The following statement: "This certificate is not proof of live birth."

(5) A certificate of birth resulting in stillbirth shall be a public record when held by an agency as defined under s. 119.011(2). The Office of Vital Statistics must inform any parent who requests a certificate of birth resulting in stillbirth that a copy of the document is available as a public record.

(6) A parent may request that the Office of Vital Statistics issue a certificate of birth resulting in stillbirth regardless of the date on which the certificate of fetal death was issued.

(7) It is final agency action, not subject to review under chapter 120, for the Office of Vital Statistics to refuse to issue a certificate to a person who is not a parent named on the fetal death certificate and who is not entitled to a certificate of birth resulting in stillbirth.

(8) The Office of Vital Statistics may not use a certificate of birth resulting in stillbirth to calculate live birth statistics.

(9) The department shall prescribe by rules adopted pursuant to ss. 120.536(1) and 120.54, the form and content of and process for issuing the certificate of birth resulting in stillbirth.

(10) Nothing in this section or s. 382.002(14) may be used to establish, bring, or support a civil cause of action seeking damages against any person or entity for bodily injury, personal injury, or wrongful death for a stillbirth.

Section 4. Paragraph (h) is added to subsection (1) of section 382.013, Florida Statutes, to read:

382.013 Birth registration.--A certificate for each live birth that occurs in this state shall be filed within 5 days after such birth with the local registrar of the district in which the birth occurred and shall be registered by the local registrar if the certificate has been completed and filed in accordance with this chapter and adopted rules. The information regarding registered births shall be used for comparison with information in the state case registry, as defined in chapter 61.

(1) FILING.--

(h) The State Registrar may receive electronically a birth certificate for each live birth which is required to be filed with the local registrar under this chapter through facsimile or other electronic transfer for the purpose of filing the birth certificate. The receipt of a birth certificate by electronic transfer constitutes delivery to the State Registrar as required by law.

Section 5. Paragraph (j) is added to subsection (1) of section 382.0255, Florida Statutes, to read:

382.0255 Fees.--

(1) The department is entitled to fees, as follows:

(j) Not less than $3 or more than $5 for processing and filing a new certificate of birth resulting in stillbirth pursuant to s. 382.0085.

Section 6. This act shall take effect July 1, 2006.

Amendment to HB 439 CS

Amendment to HB 439 CS by Rep. Planas

The amendment adds a short title to the bill. The short title of the bill is "Katherine's Law."

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No._____(for drafter's use only)

Bill No. **HB 439 CS**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health & Families Council

Representative(s) Planas offered the following:

Amendment (with directory and title amendments)

Between line(s) 47-48 and insert:

Section 1. Short Title. -- This act may be cited as "Katherine's Law."

========== T I T L E A M E N D M E N T ==========

Between line(s) 7-8 insert:

providing a short title;

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HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 483 Nursing Services
SPONSOR(S): Garcia
TIED BILLS: **IDEN./SIM. BILLS:** SB 1362

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	11 Y, 0 N	Hamrick	Mitchell
2) Insurance Committee	16 Y, 0 N	Freire	Cooper
3) Health Care Appropriations Committee	12 Y, 0 N	Speir	Massengale
4) Health & Families Council		Hamrick	Moore
5)			

SUMMARY ANALYSIS

Florida hospitals, ambulatory surgical centers, and mobile surgical centers are licensed by the Agency for Health Care Administration (agency). Pursuant to section 395.1055(1)(a), Florida Statutes, the agency shall adopt rules to ensure that sufficient numbers and qualified types of personnel and occupational disciplines are on duty and available at all time to provide necessary and adequate patient care and safety. Based upon that authority, the agency requires ambulatory surgical centers to have a registered nurse serve as an operating room circulating nurse (59A-5.0085, F.A.C.). The agency has no such requirement for hospitals. In fact, Florida is one of seven states that does not have specific staffing requirements for hospital operating rooms.

For hospitals in Florida to receive either Medicare or Medicaid payments, Centers for Medicare and Medicaid Services (CMS) requires them to comply with CMS's Conditions of Participation. According to these federal requirements, licensed practical nurses and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies.

HB 483 provides that a registered nurse shall function in a licensed facility's operating room as a circulating nurse during all operative or invasive procedures. The bill provides that a "circulating nurse" is a registered nurse who is responsible for coordinating all nursing care, patient safety needs, and the needs of the surgical team in the operating room.

According to the agency, this bill will not have a fiscal impact on state or local governments.

The bill shall take effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government-The bill increases governmental regulation of a licensed profession and hospital.

B. EFFECT OF PROPOSED CHANGES:

Florida hospitals, ambulatory surgical centers, and mobile surgical centers are licensed by the Agency for Health Care Administration (agency). Pursuant to section 395.1055(1)(a), Florida Statutes, the agency shall adopt rules to ensure that sufficient numbers and qualified types of personnel and occupational disciplines are on duty and available at all time to provide necessary and adequate patient care and safety. Based upon that authority, the agency requires ambulatory surgical centers to have a registered nurse serve as an operating room circulating nurse.[1] The agency has no such requirement for hospitals.

This bill requires hospitals to have registered nurses perform as circulating nurses in operating rooms. Whereas federal law provides that licensed practical nurses (LPNs) and surgical techs may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies, it does not require circulatory duties be performed by a registered nurse.

According to the Association of periOperative Registered Nurses (AORN), operating room (OR) nurses are now referred to as perioperative registered nurses to more accurately reflect their duties immediately before, during, and after surgery.[2] Section 464.027(2)(a), Florida Statutes, provides a definition of "perioperative nursing" to mean a practice of nursing in which the nurse provides preoperative, intraoperative, and postoperative nursing care to surgical patients.

A representative from AORN posited that this bill would raise the level of care in hospitals to match the existing requirement in the outpatient surgery centers.[3] According to a representative from the Florida Hospital Association (FHA), all hospitals in Florida already adhere to the standard of care required by the bill.[4]

Operating Room Nursing Staff
There are several roles performed by nurses in the operating room.

Registered Nurse (RN) First Assistant
The registered nurse first assistant (RNFA) directly assists the surgeon, often directly opposite the operating table during a procedure. The RNFA duties, conducted under the supervision of the surgeon, can be as basic as tying sutures, knots and performing skin closures to assist in complex surgical procedures.[5] To practice as an RNFA, a nurse must first obtain certification as a perioperative nurse (CNOR) and then attend an RNFA program.

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[1] See 59A-5.0085, F.A.C.
[2] Association of periOperative Registered Nurses, *It's important for you to know...*, available at http://www.aorn.org/About/important.htm (January 11, 2006).
[3] Email from a representative of the Association of periOperative Registered Nurses, dated February 2, 2006, on file with the Insurance Committee.
[4] Email from a representative of the Florida Hospital Association, dated February 2, 2006, on file with the Insurance Committee.
[5] Saunders, Kate. 2006. Advance Online Editions for Nurses. *Growth in the OR: The role of the registered nurse in surgery has grown and changed with technological advances.*

- A **perioperative nurse** must have a minimum of 2 full years and 2,400 hours of operating room practice as a registered nurse; and have been employed within the previous 2 years, either full-time or part-time as a registered nurse in an administrative, teaching, research, or general staff capacity in perioperative nursing.
- A **certified RNFA** must be certified as a perioperative nurse; must document 2,000 hours of practice in the RN first assistant role, with at least 500 hours in the past 2 years; must have attended a formal RNFA program; and have a bachelors degree in nursing.[6]
- In Florida, an **RNFA** must attend one academic year, or 45 hours of didactic instruction and 120 hours of clinical internship; be licensed as a registered nurse; be certified as a perioperative nurse; and hold a certificate from a recognized registered nurse first assistant program.[7]

Scrub Nurse

The scrub nurse works directly with the surgeon within the sterile field, passing instruments, sponges, and other items needed during the surgical procedure. The sterile field is the area closely surrounding the OR table and the instrument tray. Surgical team members who work within the sterile field have scrubbed their hands and arms with special disinfecting soap and wear surgical gowns, caps, gloves, shoe covers, and eyewear.[8] A scrub nurse position may be filled by a RN, an LPN, or a surgical tech.

Circulating Nurse

The circulating nurse's duties are performed outside the sterile field. The circulating nurse is responsible for managing the nursing care within the OR and performs such duties as prepping the patient, retrieving instruments, procedure documentation, dispensing medications, implementing an individualized care plan, and evaluating patient outcomes.[9] The circulating nurse observes the surgical team from a broad perspective and assists the team to create and maintain a safe, comfortable environment. The circulating nurse makes sure each member of the surgical team performs in a united effort. Currently, Florida statute does not specify the professional requirements for circulating nurses.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)[10]

Prior to 1994 the Accreditation Manual for Hospitals (AMH), required that "A qualified registered nurse is assigned to circulating nurse duties for the operating room and for the obstetric delivery room." The AMH further stated, "Other qualified operating room personnel assisting in circulating duties in the operating room and in the obstetrical delivery room are under the supervision of a qualified registered nurse who is immediately available."

In 1994, the AMH revised their manual and deleted this requirement (and limitation). At the time, a JCAHO spokesperson stated that "Determination of actual staffing is hospital specific," adding that, "If a hospital determines...that certified surgical technologists have the necessary qualifications and competencies to perform the anticipated job responsibilities, and applicable licensure, law, and regulation, and/or certification is consistent with or does not preclude such, the intent ...will be met." [11]

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[6] Nursing Center, *Certification,* available at http://www.nursingcenter.com/prodev/ce_certification.asp (January 17, 2006).
[7] See s. 464.027, F.S.
[8] Association of periOperative Registered Nurses, *It's important for you to know...*, available at http://www.aorn.org/About/important.htm (January 11, 2006).
[9] Saunders, Kate. 2006. Advance Online Editions for Nurses. *Growth in the OR: The role of the registered nurse in surgery has grown and changed with technological advances.*
[10] Under s. 395.0161(2), F.S., the agency shall accept, in lieu of its own periodic inspections for licensure, the survey or inspection of an accrediting organization, provided the accreditation of the licensed facility is not provisional and provided the licensed facility authorizes release of, and the agency receives the report of, the accrediting organization. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) qualifies as an acceptable accrediting organization. Established in 1951, JCAHO is the nation's predominant standards-setting and accrediting body in health care. *See* "Facts About the Joint Commission," available at http://www.jcaho.org/about+us/jcaho_facts.htm (February 6, 2006).
[11] "Circulating Assignment in Operating Room Clarified," Joint Commission Perspectives. Joint Commission on Accreditation of Healthcare Organizations, 1996, p 20.

Centers for Medicare and Medicaid Services

Centers for Medicare and Medicaid Services (CMS), is the federal agency that administers the Medicare, Medicaid and Child Health Insurance Programs. CMS regulations state that hospitals must be in compliance with the Federal requirements set forth in the Medicare Conditions of Participation(CoPs), in 42 CFR Part 482, in order to receive Medicare/Medicaid payment. The CoPs state that:[12]

- Hospitals must have an organized nursing service that provides 24-hour nursing services. The services must be furnished or supervised by a registered nurse.[13]
- The operating room must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy.[14]
- Licensed practical nurses (LPNs) and surgical technologists (OR techs) may serve as "scrub nurses" under the supervision of a registered nurse.[15]
- Qualified registered nurses may perform circulating duties in the operating room.
- LPNs and surgical techs may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately[16] available to respond to emergencies.[17]

State laws and regulations can be more stringent than CMS regulations, and patient care must be furnished consistent with State law.

State Regulations

State governments regulate all occupations and professions, and it is within the power of state governments to ensure patient safety through the regulation of occupations.[18] According to a report by the Association of periOperative Registered Nurses (AORN):

- 20 states require RNs to circulate,
- 37 states require RNs to supervise in the OR but do not specifically mention the role of circulating nurse,
- 8 states explicitly follow the Centers for Medicare and Medicaid Services' conditions of participation for surgical services, and
- 7 states have no specific staffing requirements.

Currently, Florida is one of seven states that have no nurse staffing requirements for hospital operating rooms (ORs). The other states are Georgia, Louisiana, Maryland, Ohio, Washington, and West Virginia. Of the 20 states that require an RN to circulate, California, Idaho, Maine, and Nevada require adequate staffing so that each RN does not circulate for more than one operating room. Hawaii, Oklahoma, Utah, and Wyoming mandate that licensed practical nurses (LPNs) and surgical technologists cannot function as the circulating nurse in the operating room. In Indiana, Nebraska, New Mexico, and Wisconsin, LPNs and surgical technologists may function as assistants under the direct supervision of a qualified RN.[19]

The eight states (i.e., Alabama, Indiana, Iowa, Massachusetts, Montana, North Dakota, New York, and Texas) that explicitly follow the Centers for Medicare and Medicaid Services' rule governing surgical

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[12] The Centers for Medicare and Medicaid Services, *Survey Protocol,* available at http://new.cms.hhs.gov/manuals/downloads/som107ap_a_hospitals.pdf (January 10, 2006).
[13] 42 CFR Part 482.23
[14] 42 CFR Part 482.51(a)(1)
[15] 42 CFR Part 482.51(a)(2)
[16] According to CMS, the supervising RN would not be considered immediately available if the RN was located outside the operating suite or engaged in other activities/duties which prevent the RN from immediately intervening and assuming whatever circulating activities/duties that were being provided by the LPN or surgical tech.
[17] 42 CFR Part 482.51 (a)(3)
[18] AORN Journal: May 2001 Health Policy Issues, *The critical "nurse" in the circulating nurse role*, available at http://www.aorn.org/journal/2001/mayhpi.htm (January 10, 2005).
[19] Ibid.

services also mandate that LPNs and surgical technologists may assist in circulatory duties under the direct supervision of a qualified RN, who is immediately available to respond to emergencies.[20]

Health Care Regulation Policy Concerns
Section 11.62(3), Florida Statute, requires the Legislature to consider the following factors in determining whether to regulate a new profession or occupation:

- That a profession or occupation is not subjected to regulation by the state unless the regulation is necessary to protect the public's health, safety, or welfare from significant and discernible harm or damage and that the police power of the state be exercised only to the extent necessary for that purpose; and

- That a profession or occupation is not regulated by the state in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the professional or occupational services to the public.

Economists argue that the regulation of health care usually involves striking a balance between patient safety and quality of care, and the cost and availability of services. Regulating quality is not without cost and it is not without an effect on the market for healthcare services. Regulations that increase the cost of providing health care may lead to increased prices, a decrease in quantity, and hurt the bottom line of the supplier of services, thus, limiting access to health care.[21]

Patient Safety and Scope of Practice
According to the Association of periOperative Registered Nurses (AORN), although unlicensed professionals may possess the technical skills to circulate, they do not have the ability to apply the nursing process to perioperative patient care. AORN further claims that to ensure patient safety, an RN must fill the role of the circulator.

C. SECTION DIRECTORY:

Section 1. Amends s. 395.0191, F.S., provides that certain nurses must be present in operating rooms and function as circulating nurses and defines the term "circulating nurse."

Section 2. Provides that the bill will take effect on July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

According to the Agency for Health Care Administration, this bill will not increase state expenditures.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

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[20] Ibid.
[21] Health Care Issues Associated with Regulation, Presentation to House Committee on Health Care Regulation, March 2005, Steve Ullmann, Ph.D., University of Miami.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals may experience a fiscal impact in implementing the provisions of this bill. Hospitals that currently allow LPNs or surgical techs to perform as "circulating nurses" will have to hire registered nurses to perform the duties of a circulating nurse. According to a 2004 National survey, registered nurses average $19.33 per hour, while licensed practical nurses average $13.58 per hour.[22]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is required to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

According to a representative from the Florida Hospital Association, this bill would "serve no purpose and would not improve the quality of care delivered in hospitals" because all of Florida's hospitals already have registered nurses serving as operating room circulating nurses.[23]

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[22] Nursing2004, *Nursing 2004 salary survey*, available at http://www.findarticles.com/p/articles/mi_qa3689/is_200410/ai_n9431354

[23] Email from a representative of the Florida Hospital Association, dated February 2, 2006, on file with the Insurance Committee.

A bill to be entitled

An act relating to nursing services; amending s. 395.0191, F.S.; requiring certain nurses to be present in operating rooms and function as circulating nurses during all operative or invasive procedures; defining the term "circulating nurse"; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (d) is added to subsection (2) of section 395.0191, Florida Statutes, to read:

395.0191 Staff membership and clinical privileges.--

(2)

(d) A registered nurse licensed under part I of chapter 464 and qualified by training and experience in operating room nursing shall be present in the operating room and function as the circulating nurse during all operative or invasive procedures. For the purposes of this paragraph, the term "circulating nurse" means a registered nurse who is responsible for coordinating all nursing care, patient safety needs, and the needs of the surgical team in the operating room during an operative or invasive procedure.

Section 2. This act shall take effect July 1, 2006.

Amendment to HB 483

Amendment to HB 483 by Rep. Garcia

Centers for Medicaid and Medicare Services (CMS) requires hospitals in the state to be in compliance with the Federal requirements set forth in the Medicare Conditions of Participation(CoPs), in 42 CFR Part 482, in order to receive Medicare/Medicaid payments.

The amendment:

- Requires hospitals to meet the requirements set forth by CMS for circulating duties performed by registered nurses in the operating room; and

- Provides that a circulating registered nurse must be in the operating room for the duration of all surgical procedures.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. (for drafter's use only)

Bill No. **0483**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	____

Council/Committee hearing bill: Health & Families Council

Representative Garcia offered the following:

Amendment (with title amendment)

Remove lines 14-22 and insert:

(d) Each hospital shall meet the requirements of the Medicare and Medicaid Conditions of Participation for Hospitals under 42 C.F.R. s. 482.51(a)(3) as they apply to registered nurses performing circulating duties in the operating room and as provided in the interpretive guidelines provided by the United States Department of Health and Human Services. A circulating nurse shall be present in the operating room for the duration of a surgical procedure.

========== T I T L E A M E N D M E N T ==========

Remove lines 3-6 and insert:

F.S.; requiring hospitals to meet the requirements of a federal regulation relating to registered nurses performing circulating duties in operating rooms; requiring circulating nurses to be present in operating rooms during specified times; providing an effective date.

redraft

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 587 CS Health Care Practitioners
SPONSOR(S): Galvano
TIED BILLS: **IDEN./SIM. BILLS:** SB 416

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 0 N, w/CS	Hamrick	Mitchell
2) Business Regulation Committee	17 Y, 0 N	Livingston	Liepshutz
3) Health Care Appropriations Committee	13 Y, 0 N, w/CS	Money	Massengale
4) Health & Families Council		Hamrick	Moore
5)			

SUMMARY ANALYSIS

House Bill 587 CS specifies that it is grounds for disciplinary action if a health care practitioner fails to identify to a patient the type of license under which he or she is practicing. The practitioner must also disclose the type of license they hold in any advertisements for health care services. The bill provides an exemption to this provision for practitioners operating in facilities licensed under chapters 394, 395 or 400, Florida Statutes, which include hospitals, ambulatory surgical centers, nursing homes, long-term care facilities, and mental health facilities.

Currently, each health profession regulated by the Department of Health is subject to the grounds for discipline listed in individual practice acts, as well as the general provisions in chapter 456, Florida Statutes. The bill amends chapter 456, Florida Statutes to apply uniformly to health care professions regulated by the Department of Health.

The bill provides rulemaking authority to each practitioner board or the department to adopt rules to determine how practitioners may comply with the disclosure requirement. The bill stipulates that the provisions of the bill are incorporated into all statutes that make a reference to section 456.072, Florida Statutes. This is designed to eliminate the need to re-enact specific penalty provisions in each practice act.

The bill does not appear to have a fiscal impact on state or local governments, but may have a fiscal impact on health care providers who have to alter their advertisements, notices, and procedures. The Department of Health suggests that disciplinary investigations and prosecutions may increase.

The bill takes effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote personal responsibility—The bill requires a physician and other health care providers such as nurses, physician assistants, mental health counselors, and opticians to disclose additional information about their credentials in advertisements and increases the enforcement responsibility of the Department of Health.

B. EFFECT OF PROPOSED CHANGES:

Present situation

The Department of Health's Division of Medical Quality Assurance

Health care practitioners in Florida are governed by professional licensing boards or councils that are independent entities that are overseen by the Department of Health's Division of Medical Quality Assurance (MQA). MQA regulates health care practitioners to ensure the health, safety and welfare of the public. Currently, MQA supports licensure and disciplinary activities for 37 professions and 6 facilities, and works with 28 boards and councils. In total, MQA regulates more than 850,000 health care practitioners and facilities.

Currently, each health profession regulated by the Department of Health is subject to the grounds for discipline listed in individual practice acts as well as the general provisions in chapter 456, Florida Statutes. Many of the regulatory boards already have rules regarding what constitutes misleading advertising.

Effect of proposed changes

The findings of the bill state that health care licensure can be extremely confusing to patients. Patients can be misled into believing that the practitioner is better qualified than other health care practitioners because of misleading practice designations.

The bill specifies that if a health care practitioner fails to identify to a patient the type of license under which he or she is practicing, it is grounds for disciplinary action. The practitioner must also disclose the type of license they hold in any advertisements for health care services. The bill provides an exemption to this provision for practitioners operating in facilities licensed under chapters 394, 395 or 400, Florida Statutes, which includes hospitals, ambulatory surgical centers, nursing homes, long-term care facilities, and mental health facilities.

The bill provides rulemaking authority to each practitioner board or the department to adopt rules to determine how practitioners may comply with the disclosure requirement. The bill stipulates that the provisions of the bill are incorporated into all statutes that make a reference to section 456.072, Florida Statutes. This eliminates the need to re-enact specific penalty provisions in each practice act.

The bill amends chapter 456, Florida Statutes to apply uniformly to health care professions regulated by the Department of Health. The bill states that patients need to be informed of the credentials of the health care practitioners who treat them, and that the public needs to be protected from misleading health care advertising.

Affected Practice Acts

The provisions of this bill will impact approximately 20 practice acts and 103 cross-references to sections 456.072, 456.072(1) and 456.072(2), Florida Statutes.

The chapters that are affected:

456	General Provisions for Health Professions	466	Dentistry, Dental Hygiene, and Dental Laboratories
457	Acupuncture	467	Midwifery
458	Medical Practice	468	Miscellaneous Professions
459	Osteopathic Medicine	478	Electrolysis
460	Chiropractic Medicine	480	Massage Practice
461	Podiatric Medicine	483	Health Testing Services
462	Naturopathy	484	Dispensing of Optical Devices and Hearing Aids
463	Optometry	486	Physical Therapy Practice
464	Nursing	490	Psychological Services
465	Pharmacy	491	Clinical, Counseling and Psychotherapy Services

Facilities Licensed in Chapters 394, 395 and 400, Florida Statutes

The bill specifies that failing to disclose the type of license a provider is operating under is grounds for disciplinary action unless the practitioner is operating in a facility licensed in chapters 394, 395 and 400, Florida Statutes.

Chapter 394, Florida Statutes, regulates the following entities:
- Mental Health Receiving Facility
- Mental Health Treatment Facility
- Private Mental Health Facilities

Chapter 395, Florida Statutes, regulates the following entities:
- Hospitals
- Ambulatory Surgical Centers
- Trauma Centers
- Rural Hospitals
- Family Practice Teaching Hospitals

Chapter 400, Florida Statutes, regulates the following entities:
- Long-term care facilities
- Nursing homes
- Assisted living facilities
- Adult day care
- Hospices
- Intermediate care and transitional facilities for developmentally disabled persons
- Prescribed pediatric extended care facilities
- Home medical equipment providers
- Health care services pools
- Health care clinics

The bill will impact practitioners in private individual and group practices.

Prohibitions on Making Misleading Advertisements

Currently, section 456.072(1)(a), Florida Statutes, prohibits making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession. In addition, grounds for discipline in each of the individual practice acts include a prohibition on false and misleading advertising. Many of the regulatory boards already have rules regarding what constitutes misleading advertising.

The bill states, "The purpose of this section is to facilitate uniform discipline for those actions made punishable under this section [s.456.072, F.S.]..." The bill further states, "a reference to this section [s.456.072, F.S.] constitutes a general reference under the doctrine of incorporation by reference." This language is designed to eliminate the need to reenact specific penalty provisions in each practice act.

C. SECTION DIRECTORY:

Section 1. Provides findings and intent of the Legislature.

Section 2. Amends s. 456.072, F. S., specifying that a practitioner's failure to disclose the type of license under which he or she is practicing is grounds for disciplinary action; the practitioner must also disclose the type of license they hold in advertisements for health care services if the practitioner is named, unless the practitioner is operating in a facility licensed under chapters 394, 395 or 400, Florida Statutes.

Section 3. Provides that the bill will take effect on July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See D. Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care providers may have to change their advertisements, notices, and office procedures to comply with the provisions of this bill.

D. FISCAL COMMENTS:

According to the Department of Health, an increase in the number of complaints of health care providers failing to fully disclose licensure information would increase the amount of disciplinary investigations and prosecutions.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides rulemaking authority to each practitioner board, or the department when there is no board, to adopt rules to determine how practitioners may comply with the disclosure requirement.

DRAFTING ISSUES OR OTHER COMMENTS:

According to the Department of Heath, the bill will help make clear to patients whether the person providing care is a physician, a physician assistant, an advanced registered nurse practitioner, other licensed professional, or an unlicensed assistant.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On February 22, 2006, the Health Care Regulation Committee adopted one amendment sponsored by Representative Galvano. The amendment removes the requirement that disclosure occurs at the initiation of the professional relationship and clarifies how a practitioner may identify himself or herself, such as by wearing of a name tag. The amendment also provides the Department of Health with rule-making authority to outline how a licensee will disclose the type of license under which he or she is practicing.

The bill, as amended, was reported favorably as a committee substitute.

On March 22, 2006, the Health Care Appropriations Committee adopted one amendment that specifies that any advertisement for health care services "naming the practitioner" must identify the type of license the practitioner holds. The amendment also adds mental health facilities licensed under chapter 394, Florida Statutes, to the exemptions for practitioners.

The bill, as amended, was reported favorably as a committee substitute. This analysis is drafted to the committee substitute.

CHAMBER ACTION

The Health Care Appropriations Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to health care practitioners; providing legislative findings and intent; amending s. 456.072, F.S., relating to grounds for discipline, penalties, and enforcement applicable to health care practitioners; providing that a practitioner's failure to identify the type of license under which he or she is practicing constitutes grounds for disciplinary action; providing exceptions; authorizing certain entities to determine compliance with a disclosure requirement; providing penalties; specifying that a reference to the section constitutes a general reference under the doctrine of incorporation by reference; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. The Legislature finds that there exists a compelling state interest in patients being informed of the

credentials of the health care practitioners who treat them and in the public being protected from misleading health care advertising. The Legislature further finds that the areas of licensure for the practice of health care can be extremely confusing for patients and that health care practitioners can easily mislead patients into believing that the practitioner is better qualified than other health care practitioners simply by creating a sham practice designation. Therefore, the Legislature has determined that the most direct and effective manner in which to protect patients from this identifiable harm is to ensure that patients and the public be informed of the training of health care practitioners and intends by this act to require the provision of the information.

Section 2. Section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.--

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(a) Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession.

(b) Intentionally violating any rule adopted by the board or the department, as appropriate.

(c) Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, a licensee's profession.

(d) Using a Class III or a Class IV laser device or product, as defined by federal regulations, without having complied with the rules adopted under ~~pursuant to~~ s. 501.122(2) governing the registration of the ~~such~~ devices.

(e) Failing to comply with the educational course requirements for human immunodeficiency virus and acquired immune deficiency syndrome.

(f) Having a license or the authority to practice any regulated profession revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of any jurisdiction, including its agencies or subdivisions, for a violation that would constitute a violation under Florida law. The licensing authority's acceptance of a relinquishment of licensure, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of charges against the license, shall be construed as action against the license.

(g) Having been found liable in a civil proceeding for knowingly filing a false report or complaint with the department against another licensee.

(h) Attempting to obtain, obtaining, or renewing a license to practice a profession by bribery, by fraudulent misrepresentation, or through an error of the department or the board.

(i) Except as provided in s. 465.016, failing to report to the department any person who the licensee knows is in violation of this chapter, the chapter regulating the alleged violator, or the rules of the department or the board.

(j) Aiding, assisting, procuring, employing, or advising any unlicensed person or entity to practice a profession contrary to this chapter, the chapter regulating the profession, or the rules of the department or the board.

(k) Failing to perform any statutory or legal obligation placed upon a licensee. For purposes of this section, failing to repay a student loan issued or guaranteed by the state or the Federal Government in accordance with the terms of the loan or failing to comply with service scholarship obligations shall be considered a failure to perform a statutory or legal obligation, and the minimum disciplinary action imposed shall be a suspension of the license until new payment terms are agreed upon or the scholarship obligation is resumed, followed by probation for the duration of the student loan or remaining scholarship obligation period, and a fine equal to 10 percent of the defaulted loan amount. Fines collected shall be deposited into the Medical Quality Assurance Trust Fund.

(l) Making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, or willfully impeding or obstructing another person to do so. Such reports or records shall include only those that are signed in the capacity of a licensee.

(m) Making deceptive, untrue, or fraudulent representations in or related to the practice of a profession or employing a trick or scheme in or related to the practice of a profession.

(n) Exercising influence on the patient or client for the purpose of financial gain of the licensee or a third party.

(o) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities the licensee knows, or has reason to know, the licensee is not competent to perform.

(p) Delegating or contracting for the performance of professional responsibilities by a person when the licensee delegating or contracting for performance of the ~~such~~ responsibilities knows, or has reason to know, the ~~such~~ person is not qualified by training, experience, and authorization when required to perform them.

(q) Violating a lawful order of the department or the board, or failing to comply with a lawfully issued subpoena of the department.

(r) Improperly interfering with an investigation or inspection authorized by statute, or with any disciplinary proceeding.

(s) Failing to comply with the educational course requirements for domestic violence.

(t) Failing to identify through written notice, which may include the wearing of a name tag, or orally to a patient the type of license under which the practitioner is practicing. Any advertisement for health care services naming the practitioner must identify the type of license the practitioner holds. This paragraph does not apply to a practitioner while the practitioner is providing services in a facility licensed under chapter 394, chapter 395, or chapter 400. Each board, or the

department where there is no board, is authorized by rule to determine how its practitioners may comply with this disclosure requirement.

(u) ~~(t)~~ Failing to comply with the requirements of ss. 381.026 and 381.0261 to provide patients with information about their patient rights and how to file a patient complaint.

(v) ~~(u)~~ Engaging or attempting to engage in sexual misconduct as defined and prohibited in s. 456.063(1).

(w) ~~(v)~~ Failing to comply with the requirements for profiling and credentialing, including, but not limited to, failing to provide initial information, failing to timely provide updated information, or making misleading, untrue, deceptive, or fraudulent representations on a profile, credentialing, or initial or renewal licensure application.

(x) ~~(w)~~ Failing to report to the board, or the department if there is no board, in writing within 30 days after the licensee has been convicted or found guilty of, or entered a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction. Convictions, findings, adjudications, and pleas entered into prior to the enactment of this paragraph must be reported in writing to the board, or department if there is no board, on or before October 1, 1999.

(y) ~~(x)~~ Using information about people involved in motor vehicle accidents which has been derived from accident reports made by law enforcement officers or persons involved in accidents under ~~pursuant to~~ s. 316.066, or using information published in a newspaper or other news publication or through a radio or television broadcast that has used information gained

from such reports, for the purposes of commercial or any other solicitation whatsoever of the people involved in the ~~such~~ accidents.

(z) ~~(y)~~ Being unable to practice with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the secretary or the secretary's designee that probable cause exists to believe that the licensee is unable to practice because of the reasons stated in this paragraph, the authority to issue an order to compel a licensee to submit to a mental or physical examination by physicians designated by the department. If the licensee refuses to comply with the ~~such~~ order, the department's order directing the ~~such~~ examination may be enforced by filing a petition for enforcement in the circuit court where the licensee resides or does business. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee or certificateholder affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that he or she can resume the competent practice of his or her profession with reasonable skill and safety to patients.

(aa) ~~(z)~~ Testing positive for any drug, as defined in s. 112.0455, on any confirmed preemployment or employer-ordered drug screening when the practitioner does not have a lawful prescription and legitimate medical reason for using the ~~such~~ drug.

(bb) ~~(aa)~~ Performing or attempting to perform health care services on the wrong patient, a wrong-site procedure, a wrong procedure, or an unauthorized procedure or a procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition. For the purposes of this paragraph, performing or attempting to perform health care services includes the preparation of the patient.

(cc) ~~(bb)~~ Leaving a foreign body in a patient, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or other diagnostic procedures. For the purposes of this paragraph, it shall be legally presumed that retention of a foreign body is not in the best interest of the patient and is not within the standard of care of the profession, regardless of the intent of the professional.

(dd) ~~(cc)~~ Violating any provision of this chapter, the applicable practice act, or any rules adopted pursuant thereto.

(ee) ~~(dd)~~ With respect to making a personal injury protection claim as required by s. 627.736, intentionally submitting a claim, statement, or bill that has been "upcoded" as defined in s. 627.732.

(ff) ~~(ee)~~ With respect to making a personal injury protection claim as required by s. 627.736, intentionally submitting a claim, statement, or bill for payment of services that were not rendered.

(gg) ~~(ff)~~ Engaging in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a

violation of any provision of this chapter, a violation of the applicable practice act, or a violation of any rules adopted under ~~pursuant to~~ this chapter or the applicable practice act of the prescribing practitioner. Notwithstanding s. 456.073(13), the department may initiate an investigation and establish such a pattern from billing records, data, or any other information obtained by the department.

(hh) ~~(gg)~~ Being terminated from a treatment program for impaired practitioners, which is overseen by an impaired practitioner consultant as described in s. 456.076, for failure to comply, without good cause, with the terms of the monitoring or treatment contract entered into by the licensee, or for not successfully completing any drug treatment or alcohol treatment program.

(2) When the board, or the department when there is no board, finds any person guilty of the grounds set forth in subsection (1) or of any grounds set forth in the applicable practice act, including conduct constituting a substantial violation of subsection (1) or a violation of the applicable practice act which occurred prior to obtaining a license, it may enter an order imposing one or more of the following penalties:

(a) Refusal to certify, or to certify with restrictions, an application for a license.

(b) Suspension or permanent revocation of a license.

(c) Restriction of practice or license, including, but not limited to, restricting the licensee from practicing in certain settings, restricting the licensee to work only under designated conditions or in certain settings, restricting the licensee from

performing or providing designated clinical and administrative services, restricting the licensee from practicing more than a designated number of hours, or any other restriction found to be necessary for the protection of the public health, safety, and welfare.

(d) Imposition of an administrative fine not to exceed $10,000 for each count or separate offense. If the violation is for fraud or making a false or fraudulent representation, the board, or the department if there is no board, must impose a fine of $10,000 per count or offense.

(e) Issuance of a reprimand or letter of concern.

(f) Placement of the licensee on probation for a period of time and subject to such conditions as the board, or the department when there is no board, may specify. Those conditions may include, but are not limited to, requiring the licensee to undergo treatment, attend continuing education courses, submit to be reexamined, work under the supervision of another licensee, or satisfy any terms which are reasonably tailored to the violations found.

(g) Corrective action.

(h) Imposition of an administrative fine in accordance with s. 381.0261 for violations regarding patient rights.

(i) Refund of fees billed and collected from the patient or a third party on behalf of the patient.

(j) Requirement that the practitioner undergo remedial education.

In determining what action is appropriate, the board, or department when there is no board, must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the practitioner. All costs associated with compliance with orders issued under this subsection are the obligation of the practitioner.

(3)(a) Notwithstanding subsection (2), if the ground for disciplinary action is the first-time failure of the licensee to satisfy continuing education requirements established by the board, or by the department if there is no board, the board or department, as applicable, shall issue a citation in accordance with s. 456.077 and assess a fine, as determined by the board or department by rule. In addition, for each hour of continuing education not completed or completed late, the board or department, as applicable, may require the licensee to take 1 additional hour of continuing education for each hour not completed or completed late.

(b) Notwithstanding subsection (2), if the ground for disciplinary action is the first-time violation of a practice act for unprofessional conduct, as used in ss. 464.018(1)(h), 467.203(1)(f), 468.365(1)(f), and 478.52(1)(f), and no actual harm to the patient occurred, the board or department, as applicable, shall issue a citation in accordance with s. 456.077 and assess a penalty as determined by rule of the board or department.

(4) In addition to any other discipline imposed through final order, or citation, entered on or after July 1, 2001, under ~~pursuant to~~ this section or discipline imposed through final order, or citation, entered on or after July 1, 2001, for a violation of any practice act, the board, or the department when there is no board, shall assess costs related to the investigation and prosecution of the case. The ~~Such~~ costs related to the investigation and prosecution include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by the attorney and other personnel working on the case, and any other expenses incurred by the department for the case. The board, or the department when there in no board, shall determine the amount of costs to be assessed after its consideration of an affidavit of itemized costs and any written objections thereto. In any case where the board or the department imposes a fine or assessment and the fine or assessment is not paid within a reasonable time, the ~~such~~ reasonable time to be prescribed in the rules of the board, or the department when there is no board, or in the order assessing the ~~such~~ fines or costs, the department or the Department of Legal Affairs may contract for the collection of, or bring a civil action to recover, the fine or assessment.

(5) In addition to, or in lieu of, any other remedy or criminal prosecution, the department may file a proceeding in the name of the state seeking issuance of an injunction or a writ of mandamus against any person who violates any of the provisions of this chapter, or any provision of law with respect

to professions regulated by the department, or any board therein, or the rules adopted pursuant thereto.

(6) If ~~In the event~~ the board, or the department when there is no board, determines that revocation of a license is the appropriate penalty, the revocation shall be permanent. However, the board may establish by rule requirements for reapplication by applicants whose licenses have been permanently revoked. The ~~Such~~ requirements may include, but are ~~shall~~ not ~~be~~ limited to, satisfying current requirements for an initial license.

(7) The purpose of this section is to facilitate uniform discipline for those actions made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.

Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 747 CS Health Professionals Treating Speech or Hearing Disorders
SPONSOR(S): Greenstein
TIED BILLS: **IDEN./SIM. BILLS:** SB 370

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	11 Y, 0 N, w/CS	Hamrick	Mitchell
2) Health Care Appropriations Committee	13 Y, 0 N	Money	Massengale
3) Health & Families Council		Hamrick	Moore
4)			
5)			

SUMMARY ANALYSIS

House Bill 747 CS revises the requirements for Department of Health's Board of Speech-Language Pathology and Audiology to issue licenses and provisional licenses to practice as a speech-language pathologist or audiologist in Florida. By January 1, 2008, the audiology profession in Florida will transition to expanded educational requirements and requirement of a doctoral degree.

The bill provides that applicants requesting a provisional license as a speech-language pathologist or audiologist must meet certain requirements in the areas of academic course work, practicum experience, and supervised clinical experience or professional employment. The bill also revises the licensure requirements for foreign trained or out-of-state applicants.

The bill requires applicants requesting licensure as an audiologist to have a minimum of 11 months of full-time professional employment. Currently, speech-language pathologists and audiologists must have 9 months of full-time professional employment. The bill provides that the board may certify an audiologist for licensure if an applicant has earned a doctoral degree in audiology and passed an examination. Currently, an a applicant seeking licensure to practice as a speech-language pathologist or audiologist is required to complete the education and supervised clinical requirements, the professional experience requirement, and pass an examination.

The bill requires a speech-language assistant or audiology assistant to have a plan for on-the-job training and decreases the educational requirements for audiology assistants. An audiologist or speech-language pathologist, who employs an assistant, is responsible for all the services performed by the assistant.

According to the Department of Health, if the board is required to determine equivalency of training for foreign trained applicants, the department will incur costs to translate transcripts and to hire education program experts to determine program equivalency which may increase or generate litigation issues.

The bill takes effect July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government—The bill requires the Department of Health to determine the equivalency of education for foreign trained health professionals requesting a license or provisional license to practice as a speech-language pathologist or audiologist in Florida.

B. EFFECT OF PROPOSED CHANGES:

The bill revises the requirements for Department of Health's Board of Speech-Language Pathology and Audiology to issue licenses and provisional licenses to practice as a speech-language pathologist and audiologist.

Professional Training Requirements for Speech-Language Pathology and Audiology
Frequent changes in the academic and clinical requirements for accreditation have led to the need for revisions to Florida's practice act for speech-language pathology and audiology. In 1997, the profession of Speech Language Pathology and Audiology became regulated. The Educational Testing Service completed national skills validation studies for both professions and concluded that the knowledge and skills of practitioners must be expanded to assure good quality care to the persons both professions serve.

Florida universities were the first in the nation to transition all accredited university training programs to the Doctor of Audiology degree. The University of Florida (UF), University of South Florida (USF), and Nova Southeastern University are the only universities in Florida with audiology programs and each offer the Doctor of Audiology degree.

By January 1, 2008, the audiology profession in Florida will transition to expanded educational requirements and requirement of a doctoral degree. Speech-language pathology will remain at the master's entry-level for clinical practice, also with expanded knowledge and skills and competency-based assessment as of January 1, 2005. Speech-language pathology master's degree programs in Florida currently meet the expanded standards that became effective on January 1, 2005.

Practice Act for Speech-Language Pathology and Audiology
The bill changes requirements for licensure for speech-language pathologist and audiologist to increase the educational standards so that they are concurrent with the national trends that are evolving and will continue to over the next several years.

The bill replaces the requirements for specified hours of course work and clinical experience with requirements for specific areas of knowledge and skills that are appropriate to completed accredited degree programs. The bill revises the requirements for licensure by endorsement, provisional licenses, provisional licensure for foreign trained professionals, and certification of speech-language pathology assistants and audiology assistants.

The bill increases the educational requirements for licensure in audiology to a doctoral degree in audiology. A transition period is provided to master's degree recipients so they may qualify for a provisional license, which is good for 24 months, until they meet the higher educational requirements of a doctoral degree in audiology. The bill provides that the board may certify an audiologist for licensure if an applicant has obtained a doctoral degree in audiology and passed the required examination.

Effective January 1, 2008, an audiologist who has earned a master's degree in a program with a major emphasis in audiology or earned a doctoral degree in audiology but not passed the license examination is eligible to receive a provisional license.

Until January 1, 2013, the board may waive the education, practicum, and professional employment requirements of foreign trained provisional licensure applicants, if the board is satisfied that an applicant meets the equivalency requirements and passes the examination in speech-language pathology or audiology.

Currently, speech-language pathologists and audiologists must have 9 months of full-time professional employment prior to licensure.[1] The bill requires applicants requesting licensure as an audiologist to have a minimum of 11 months of full-time professional employment.

The bill provides language that broadens the recognition of accredited schools or institutions of higher learning, to include schools that are accredited by the U.S. Department of Education or a successor to the Council for Higher Education Accreditation. The bill also decreases the educational requirements for audiology assistants by removing the 24 semester hours of course work required for certification and specifies that audiology assistants must possess at least a high school diploma or its equivalent.

The bill requires an audiologist or speech-language pathologist to provide their assistants with a work plan approved by the board for on-the-job training. An audiologist or speech-language pathologist, who employs an assistant, is responsible for all the services performed by the assistant.

BACKGROUND INFORMATION

In 1995, approximately 46 million people in the United States of all ages, races and gender, experienced or lived with some type of communication disorder.[2] According to the American Speech-Language Hearing Association, 28 million individuals have a hearing loss.[3]

Audiologists, speech-language pathologists, and speech, language, and hearing scientists are professionals who evaluate, treat, and conduct research into human communication and its disorders. Speech and language disorders are inabilities of individuals to understand and/or appropriately use the speech and language systems of society. Such disorders may range from simple sound repetitions or occasional misarticulations to the complete absence of the ability to use speech and language for communication.

National Certification by the American Speech-Language and Hearing Association

The American Speech-Language Hearing Association provides voluntary certification for speech-language pathologists and audiologists. In 1997, the American Board of Audiology was founded to provide voluntary board certification for audiologists.

American Speech-Language Hearing Association Requirements for the Certificate of Clinical Competence

Applicants for the American Speech-Language Hearing Association Certificate of Clinical Competence (C.C.C.) must have a master's or a doctoral degree. Candidates for certification must have completed at least 27 semester credit hours in basic science course work; 36 semester credit hours in professional coursework; 375 clock hours of supervised clinical observation/practice; a clinical fellowship that encompasses 36 weeks of full-time professional experience; and successfully pass the national examination.

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[1] See s. 468.1165, F.S.

[2] American Speech-Language Pathology Association, *Speech-Language Disorders and the Speech-Language Pathologist*, http://www.asha.org/students/professions/overview/sld.htm

[3] A Decade of Progress Ahead. *1990 Annual Report of the National Deafness and Other Communication Disorders Advisory Board.* http://www.asha.org/students/professions/overview/hla.htm

American Speech-Language Hearing Association Requirements for Certification in Audiology
Demonstration of continued professional development is mandated for maintenance of the Certificate of Clinical Competence in Audiology. This standard took effect on January 1, 2003. The certification is good for three years. The new professional development standard will apply to all certificate holders, regardless of the date of initial certification. Individuals who hold the Certificate of Clinical Competence in Audiology must accumulate 30 contact hours of professional development over the three-year period to meet this standard.[4]

C. SECTION DIRECTORY:

Section 1. Amends s. 468.1155, F. S., revising the requirements of issuing provisional licenses to speech-language pathologists and audiologists.

Section 2. Amends s. 468.1165, F. S., increasing the time requirement for professional employment experience.

Section 3. Amends s. 468.1185, F. S., revising requirements to issue a license to an applicant to practice audiology.

Section 4. Amends section 468.1215, F. S., revising on-the-job training requirements by requiring a work plan for speech-language pathology assistants and audiology assistants; removes the college coursework requirements for audiology assistants and requires them to have at least a high school diploma or its equivalent.

Section 5. Provides the bill will take effect July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments section below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There may be costs associated with the additional education requirement. The practitioners will be better educated to provide the appropriate care.

[4] American Speech-Language Pathology Association, *Certification Maintenance Guidelines for Audiology*, http://www.asha.org/about/membership-certification/certification/standard6_aud_guide.htm

D. FISCAL COMMENTS:

According to the Department of Health (DOH), if the board is required to determine equivalency of training for foreign trained applicants, there may be a cost associated with translations of transcripts and the hiring of education program experts to determine program equivalency. These costs can be reduced or eliminated by allowing the board to rely on professional credentials review organizations. There may be an increase in litigation because of the equivalency determination required of the board. A foreign educated speech–language pathologist or audiologist who is denied a license may challenge the board over the correctness of the denial.

According to DOH, the department may incur minimal costs relating to rulemaking under the bill. The board will also need to update the licensure application to include the acceptance of the American Board of Audiology certification for applicants seeking licensure by endorsement to practice as an audiologist in Florida.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides the Board of Speech-Language Pathology and Audiology the authority required to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The Board of Speech-Language Pathology and Audiology created a review panel to look at any needed changes to the current statutory provisions, specifically focusing on educational standards. The intent of the recommendations from this panel and the board as a whole are encompassed in this bill.

According to the board, the intent of the language is to provide the board with authority to increase the educational standards concurrent with the national trends that are evolving and will continue to over the next several years. These changes include requiring more education and clinical experience prior to licensure, but are significantly delayed by section 1(3)(c) of the bill. This section deals with the provisional licensure for applicants who have earned a master's degree with a major emphasis in audiology and provides a grandfather clause for them until January 2008 or January 2013 for foreign trained applicants.

<u>Litigation Concerns in Determining Foreign Trained Education Equivalency</u>
According to DOH, the bill may increase or generate litigation issues. A foreign educated speech–language pathologist or audiologist who is denied a license may challenge the board over the correctness of the denial. Board members will have to become education program experts or will have to hire educational program experts to determine whether the applicant "meets the equivalent" education and practicum requirements. Similarly, there may be litigation over when and whether the

board should "waive" the education, practicum, and professional employment experience because the applicant obtained "the equivalent" elsewhere. Foreign transcripts and documentation will also have to be translated into English.

According to the department, foreign trained applicants must present documentation of the determination of equivalency by the Council for Higher Education to qualify for a provisional license.

The board indicated that the determination of equivalency should be made by the credentialing experts who report to the board but are paid for by the applicants as is the case in other professions. The board states that allowing them to rely on the expert opinions of a professional credential review company that can evaluate the educational background of foreign graduates might discourage or limit some of the litigation.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 8, 2005 the Health Care Regulation Committee adopted two amendments. One was offered by the bill's sponsor and the other by Representative Proctor. Both amendments were technical and clarified the intent of the bill, specifically, licensure requirements for audiologists. The amendments clarified that an applicant who has received a doctoral degree in audiology meets or satisfies the requirements for education and supervised clinical requirements and the professional experience requirements, but they must still pass the required examination.

The bill was reported favorably as a committee substitute. This analysis is drafted to the committee substitute.

CHAMBER ACTION

The Health Care Regulation Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to health professionals treating speech or hearing disorders; amending s. 468.1155, F.S.; revising requirements for the Department of Health in issuing a provisional license to practice speech-language pathology or audiology; revising licensing requirements for applicants who graduated or are currently enrolled in a speech-language pathology or audiology program at a university located outside of the United States or Canada; authorizing the Board of Speech-Language Pathology and Audiology to waive certain requirements for applicants who received professional education in another country under certain circumstances; amending s. 468.1165, F.S.; revising requirements for applicants to obtain professional employment in order to be licensed by the department to practice speech-language pathology or audiology; amending s. 468.1185, F.S.; revising requirements for the department to issue a license to an applicant to practice speech-language pathology or

audiology; amending s. 468.1215, F.S.; revising requirements for a person to be certified as an audiology assistant; requiring an audiologist or speech-language pathologist to give an assistant a board-approved plan for training and to maintain responsibility for services performed by the assistant; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 468.1155, Florida Statutes, is amended to read:

468.1155 Provisional license; requirements.--

(1)(a) A provisional license shall be required of all applicants <u>for a license in speech-language pathology</u> who cannot document <u>a minimum of</u> 9 months of supervised professional employment experience <u>and a passing score on the national examination. A provisional license shall be required of all applicants for a license in audiology who cannot document a minimum of 11 months of supervised clinical experience</u> and a passing score on the national examination.

(b) Individuals who are required to hold a provisional license under paragraph (a) shall apply to the department and be certified by the board for licensure prior to initiating the professional employment experience required pursuant to s. 468.1165.

(2) The department shall issue a provisional license to practice speech-language pathology to each applicant who the board certifies has:

(a) Completed the application form and remitted the required fees, including a nonrefundable application fee.

(b) Received a master's degree or completed the academic requirement of ~~is currently enrolled in~~ a doctoral degree program with a major emphasis in speech-language pathology from an institution of higher learning that ~~which~~ is, or at the time the applicant was enrolled and graduated was, accredited by an accrediting agency recognized by the Council for Higher Education Accreditation or its successor or the United States Department of Education or from an institution that ~~which~~ is a member in good standing with the Association of Universities and Colleges of Canada. An applicant who graduated from or is currently enrolled in a program at a university or college outside the United States or Canada must present documentation of the determination of equivalency of the program to standards established by an accrediting body recognized by the Council for Higher Education Accreditation or its successor or the United States Department of Education in order to qualify.

1. The applicant must have completed the program requirements by academic course work, practicum experience, or laboratory or research activity, as verified by the program, including:

a. Knowledge of basic human communication and swallowing processes, including their biological, neurological, acoustic, psychological, developmental, and linguistic and cultural bases.

b. Knowledge of the nature of speech, language, hearing, and communication disorders and differences and swallowing disorders, including their etiologies; anatomical or

physiological characteristics; acoustic, psychological, developmental, and linguistic and cultural correlates; voice and resonance, including respiration and phonation; receptive and expressive language in speaking, listening, reading, writing, and manual modalities; hearing, including the impact on speech and language; swallowing; cognitive aspects of communication; social aspects of communication; and communication modalities.

c. Knowledge of the principles and methods of prevention, assessment, and intervention for people having communication and swallowing disorders, including consideration of anatomical or physiological, psychological, developmental, and linguistic and cultural correlates of the disorders, articulation, fluency, voice and resonance, receptive and expressive communication, hearing, swallowing, cognitive aspects of communication, social aspects of communication, and communication modalities.

2. The program must include appropriate supervised clinical experiences.

The board may waive the requirements for education, practicum, and professional employment experience for an applicant who received a professional education in another country if the board is satisfied that the applicant meets the equivalent education and practicum requirements and passes the examination in speech-language pathology. ~~60 semester hours that include:~~

~~1. Fundamental information applicable to the normal development and use of speech, hearing, and language; information about training in management of speech, hearing, and~~

~~language disorders; and information supplementary to these fields.~~

~~2. Six semester hours in audiology.~~

~~3. Thirty of the required 60 semester hours in courses acceptable toward a graduate degree by the college or university in which these courses were taken, of which 24 semester hours must be in speech-language pathology.~~

~~(c) Completed 300 supervised clinical clock hours with 200 clock hours in the area of speech-language pathology or completed the number of clock hours required by an accredited institution meeting national certification standards. The supervised clinical clock hours shall be completed within the training institution or one of its cooperating programs.~~

(3) The department shall issue a provisional license to practice audiology to each applicant who the board certifies has:

(a) Completed the application form and remitted the required fees, including a nonrefundable application fee.

(b) Effective January 1, 2008, earned a doctoral degree in audiology, but has not passed the license examination required for a license in audiology or has completed the academic requirements of ~~Received a master's degree or is currently enrolled in~~ a doctoral degree program with a major emphasis in audiology from an institution of higher learning that ~~which~~ is, or at the time the applicant was enrolled and graduated was, accredited by an accrediting agency recognized by the Council for Higher Education Accreditation or its successor or the United States Department of Education or from an institution

that ~~which~~ is a member in good standing with the Association of Universities and Colleges of Canada. An applicant who graduated from or is currently enrolled in a program at a university or college outside the United States or Canada must present documentation of the determination of equivalency of the program to standards established by an accrediting body recognized by the Council for Higher Education Accreditation or its successor or the United States Department of Education in order to qualify.

1. The program must ensure that the student obtained knowledge of foundation areas of basic body systems and processes related to hearing and balance.

2. The program must ensure that the student obtained skills for the diagnosis, management, and treatment of auditory and vestibular or balance conditions and diseases.

3. The program must ensure that the student can effectively communicate with patients and other health care professionals.

4. The program must ensure that the student obtained knowledge of professional ethical systems as they relate to the practice of audiology.

5. The program must ensure that the student obtained clinical experiences that encompass the entire scope of practice and focus on the most current evidence-based practice.

The board may waive the education, practicum, and professional employment experience requirements for an applicant who received a professional education in another country if the board is

satisfied that the applicant meets equivalent education and practicum requirements and passes the examination in audiology.

(c) Has earned a master's degree with a major emphasis in audiology which was conferred before January 1, 2008, from an institution of higher learning which was, or at the time the applicant was enrolled and graduated, accredited by an accrediting agency recognized by the Council for Higher Education Accreditation or its successor or the United States Department of Education or from an institution that is a member in good standing with the Association of Universities and Colleges of Canada.

1. An applicant who graduated from or is currently enrolled in a program at a university or college outside the United States or Canada must present documentation of the determination of equivalency of the program to standards established by an accrediting body recognized by the Council for Higher Education Accreditation or its successor or the United States Department of Education in order to qualify.

2. The board may waive the education, practicum, and professional employment experience requirements for an applicant who received a professional education in another country if the board is satisfied that the applicant meets equivalent education and practicum requirements and passes the examination in audiology. This paragraph expires January 1, 2013. ~~The applicant must have completed 60 semester hours that include:~~

~~1. Fundamental information applicable to the normal development and use of speech, hearing, and language; information about training in management of speech, hearing, and~~

~~language disorders; and information supplementary to these fields.~~

~~2. Six semester hours in speech-language pathology.~~

~~3. Thirty of the required 60 semester hours in courses acceptable toward a graduate degree by the college or university in which these courses were taken, of which 24 semester hours must be in audiology.~~

~~(c) Completed 300 supervised clinical clock hours with 200 clock hours in the area of audiology or completed the number of clock hours required by an accredited institution meeting national certification standards. The supervised clinical clock hours shall be completed within the training institution or one of its cooperating programs.~~

~~(4) An applicant who has received a master's degree or is currently enrolled in a doctoral degree program with a major emphasis in speech-language pathology as provided in subsection (2), or audiology as provided in subsection (3), and who seeks licensure in the area in which the applicant is not currently licensed, must have completed 30 semester hours in courses acceptable toward a graduate degree and 200 supervised clinical clock hours in the second discipline from an accredited institution.~~

(4) ~~(5)~~ The board, by rule, shall establish requirements for the renewal of a provisional license. However, a provisional license may not exceed a period of 24 months.

Section 2. Section 468.1165, Florida Statutes, is amended to read:

468.1165 Professional employment experience requirement.--Every applicant for licensure as a speech-language ~~speech~~ pathologist must ~~or audiologist shall~~ demonstrate, prior to licensure, a minimum of 9 months of full-time professional employment~~,~~ or the equivalent in part-time professional employment~~, pertinent to the license being sought~~. Each applicant for licensure as an audiologist must demonstrate, prior to licensure, a minimum of 11 months of full-time professional employment or the equivalent in part-time professional employment. The board, by rule, shall establish standards for obtaining and verifying the required professional employment experience.

Section 3. Subsections (2) and (3) of section 468.1185, Florida Statutes, are amended to read:

468.1185 Licensure.--

(2)(a) The board shall certify for licensure any applicant who has:

1.~~(a)~~ Satisfied the education and supervised clinical ~~clock hour~~ requirements of s. 468.1155.

2.~~(b)~~ Satisfied the professional experience requirement of s. 468.1165.

3.~~(c)~~ Passed the licensure examination required by s. 468.1175.

(b) An applicant for an audiologist license who has passed the licensure requirements of s. 468.1175 and obtained a doctoral degree in audiology has satisfied the education and supervised clinical requirements of subparagraph (2)(a)1. and

the professional experience requirements of subparagraph (2)(a)2.

(3) The board shall certify as qualified for a license by endorsement as a speech-language pathologist or audiologist an applicant who:

(a) Holds a valid license or certificate in another state or territory of the United States to practice the profession for which the application for licensure is made, if the criteria for issuance of such license were substantially equivalent to or more stringent than the licensure criteria which existed in this state at the time the license was issued; or

(b) Holds a valid ~~Has received the~~ certificate of clinical competence of the American Speech-Language and Hearing Association or board certification in audiology from the American Board of Audiology.

Section 4. Subsections (2), (3), and (4) of section 468.1215, Florida Statutes, are amended to read:

468.1215 Speech-language pathology assistant and audiology assistant; certification.--

(2) The department shall issue a certificate as an audiology assistant to each applicant who the board certifies has:

(a) Completed the application form and remitted the required fees, including a nonrefundable application fee.

(b) Earned a high school diploma or its equivalent. ~~Completed at least 24 semester hours of coursework as approved by the board at an institution accredited by an accrediting~~

~~agency recognized by the Council for Higher Education Accreditation.~~

(3) An audiologist or speech-language pathologist who employs a speech-language assistant or audiology assistant must provide the assistant with a plan approved by the board for on-the-job training and must maintain responsibility for all services performed by the assistant. The board, by rule, shall establish minimum education and on-the-job training and supervision requirements for certification as a speech-language pathology assistant or audiology assistant.

(4) The provisions of this section shall not apply to any student, intern, or trainee performing speech-language pathology or audiology services while completing the supervised clinical experience ~~clock hours~~ as required in s. 468.1155.

Section 5. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 947 CS Long-Term Care Coverage
SPONSOR(S): Legg
TIED BILLS: **IDEN./SIM. BILLS:** SB 1924

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder & Long-Term Care Committee	7 Y, 0 N, w/CS	DePalma	Walsh
2) Insurance Committee	17 Y, 0 N	Tinney	Cooper
3) Health Care Appropriations Committee	13 Y, 0 N, w/CS	Speir	Massengale
4) Health & Families Council		DePalma	Moore
5)			

SUMMARY ANALYSIS

The bill directs the Agency for Health Care Administration to establish the Florida Long-Term Care Partnership Program, in compliance with the requirements of the Social Security Act as amended by the federal Deficit Reduction Act of 2005, and in consultation with the Office of Insurance Regulation and the Department of Children and Family Services.

In addition to providing certain program requirements, the bill also provides that, for purposes of determining Medicaid eligibility, assets in an amount equal to the insurance benefit payments made to, or on behalf of, an individual who is a beneficiary under an approved Florida Long-Term Care Partnership Program policy shall be disregarded. Essentially, this enables Floridians to qualify for coverage of the substantial costs associated with provision of long-term care services under Medicaid without first being required to substantially exhaust—or "spend down"—assets and resources.

The bill also requires the Office of Program Policy and Governmental Analysis to prepare a report on the implementation of the Florida Long-Term Care Partnership Program. The report shall be provided to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2009.

The full fiscal impact to Florida is unknown at this time. While most of these programs are Medicaid budget-neutral in other states, the fiscal impact on Florida is unknown. Medicaid may incur expenses related to insurance deductibles and premiums, depending on the final approved structure of the program.

The bill is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government—Floridians' participation in a long-term care insurance partnership program may reduce Medicaid spending on long-term nursing facility services presently provided to Medicaid-eligible individuals without long-term care insurance coverage.

Safeguard Individual Liberty—The bill restructures the method used for Medicaid asset determinations by providing a mechanism for individuals to qualify for coverage of the costs of long-term care needs under Medicaid without first being required to substantially exhaust or "spend down" personal resources and assets.

Promote Personal Responsibility—The goal of the Florida Long-Term Care Partnership Program is to encourage citizens in Florida to purchase long-term care insurance coverage, thus alleviating or postponing the need for public funds to pay for long-term care.

Empower Families—Individuals ineligible for the long-term care services provided by Medicaid—but also with income levels making private long-term care coverage unaffordable—may be able to purchase long-term care from participating providers under the partnership program.

B. EFFECT OF PROPOSED CHANGES:

Background

Long-Term Care

"Long-term care" refers to a broad range of assistive medical, personal, and social services needed by individuals who are unable to meet their basic living needs for an extended period of time, often as result of accident, illness or frailty. Frequently, such individuals demonstrate an inability to move about, dress, bathe, eat, use a toilet or follow medication schedules. Consequently, assistance is often necessary to help with daily household cleaning, meal preparation, shopping, bill paying, medical visits, and administration of medication, among various other tasks. Additional long-term care disabilities may be attributable to cognitive impairment associated with stroke, depression, dementia, Alzheimer's disease, Parkinson's disease, and other medical conditions affecting the brain.

In testimony provided before the United States Senate Special Committee on Aging in March, 2002, the Comptroller General of the United States indicated that long-term care expenditures for persons of all ages totaled $137 billion in 2000, and announced that spending on long-term care services for the nation's elderly population is projected to nearly quadruple to $379 billion by 2050.[1] In 2005, roughly 9 million individuals 65 and older required long-term care services, and by 2020 it is projected that 12 million older Americans will need some form of long-term care assistance.[2] A study by the U.S. Department of Health and Human Services says that people who reach age 65 will likely have a 40 percent chance of entering a nursing home, and about 10 percent of those entering a nursing home facility will stay there five or more years.[3]

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[1] *Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets*, GAO-02-544T, March 21, 2002, statement of Comptroller General of the United States before the U.S. Senate Special Committee on Aging, available at: http://www.gao.gov/new.items/d02544t.pdf.

[2] *Long-Term Care*, accessed February 17, 2006, the Official U.S. Government Site for People with Medicare, available at: http://www.medicare.gov/LongTermCare/Static/Home.asp.

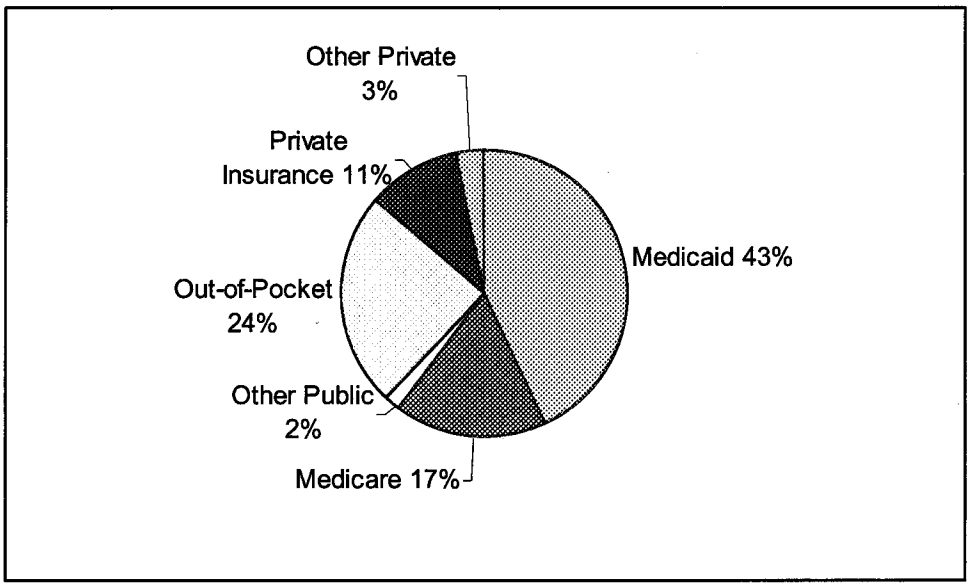
[3] United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, March 2005.

Long-Term Care Financing

The costs associated with long-term care services are substantial. The average cost of a nursing home stay is more than $55,000 per year, and as much as $100,000 in some urban areas. Hourly home care agency rates average $37 for a licensed practical nurse, and $18 for a home health aide.[4]

Medicaid is now the primary payer of long-term care services in the United States (see figure 1),[5] and, as a result, state and federal governments bear a large financial burden for providing these services. The state of Florida is particularly affected, as it has the highest proportion of individuals age 65 to 84 of any state in the nation, and this elderly population is expected to grow 130 percent by 2025.[6] In Fiscal Year 2002-03, Florida Medicaid spent $3.2 billion (28 percent of the total Medicaid budget) on four core long-term care services: nursing homes, Intermediate Care Facilities for Persons with Developmental Disabilities, Home and Community-Based Services waivers, and assistive care services.[7] Florida Medicaid currently pays for nearly two-thirds of all nursing home days for the state's frail elders.

Figure 1. Sources of Long-Term Care Payments, 2003



Source: *Medicaid and Long-Term Services and Supports for Older People*, AARP Public Policy Institute 2005

Seniors often believe that Medicare, the nearly universal source of acute health care coverage for individuals 65 and older, pays for a vast array of long-term care services.[8] However, many common long-term care needs (e.g., bathing, dressing, and other household chores) do not require skilled help and, therefore, are not generally covered by Medicare.[9] Consequently, many seniors are left attempting to "spend down" their assets in an effort to satisfy Medicaid asset and income criteria, thereby gaining eligibility for Medicaid services.

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[4] *Long-Term Care Insurance*, September 2004, AARP Public Policy Institute, available at: http://assets.aarp.org/rgcenter/health/fs7r_ltc.pdf.
[5] *Medicaid and Long-Term Services and Supports for Older People*, February 2005, AARP Public Policy Institute, available at: http://assets.aarp.org/rgcenter/post-import/fs18r_medicaid_05.pdf.
[6] *Model Long-Term Care System: Analyzing Long-Term Care Initiatives in Florida*, November 2003, Florida Senate Interim Project 2004-144, available at: http://www.flsenate.gov/data/Publications/2004/Senate/reports/interim_reports/pdf/2004-144hc.pdf.
[7] *Medicaid Long-Term Care: Overview and Update*, December 15, 2004, Agency for Health Care Administration presentation to the Senate Health and Human Services Appropriations Committee, available at: http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/ltc_overview_and_update_121504.pdf.
[8] *Medicaid and Long-Term Services and Supports for Older People*, AARP Public Policy Institute, *supra*.
[9] *Long-Term Care Insurance*, AARP Public Policy Institute, *supra*.

As an alternative to spending assets to qualify for Medicaid or complete self-financing, a market for private long-term care insurance has developed, and grown, in recent years. However, the premiums typically associated with high-quality private insurance coverage exceed the resources of many Americans.[10] In 2001, the average annual premium of long-term care insurance, if bought at age 65, exceeded $2,300[11] and most estimates indicate that only 10-20 percent of seniors can presently afford private long-term care insurance.[12]

In response, states have adopted several strategies to encourage younger individuals to purchase private long-term care insurance. States frequently offer tax incentives to individuals or employers to purchase private long-term care coverage; however, tax deductions tend to be small, and often don't constitute a significant savings for either employers or individual purchasers. Alternatively, many states have begun offering long-term care insurance to state employees and retirees as part of state benefits packages. Finally, several states have explored the possibility of public/private insurance partnerships between state government and private insurance companies. Under this approach, individuals with moderate income are encouraged to purchase private long-term care insurance to fund their long-term care needs rather than divesting their assets and relying on Medicaid assistance—effectively reducing or delaying the need for Medicaid assistance.

Long-Term Care Partnership Program

The Long-Term Care Partnership Program began in 1987 as a demonstration project funded through the Robert Wood Johnson Foundation (RWJF).[13] As part of the demonstration project, four out of the original eight states with RWJF planning grants—California, Connecticut, Indiana and New York—ultimately implemented partnership programs.

With the help of the National Program Office, located at the University of Maryland Center on Aging, states participating in the planning phase of the partnership programs developed strategies to encourage the purchase of private long-term care insurance policies. The states recognized that, in addition to decreasing the costs of these policies, it was equally important to increase the quality of coverage being offered in order to broaden the market for long-term care insurance.

Ultimately, a unique approach emerged, whereby individuals purchasing a state-certified long-term care insurance "partnership" policy first rely on benefits from their private long-term care insurance policy to cover long-term care costs. Thereafter, if insurance benefits are exhausted, the policyholders are allowed to protect some or all of their assets from Medicaid "spend-down" requirements during the eligibility determination process (though certain other income requirements must still be satisfied).[14]

Essentially, the general goal of long-term care partnership programs is to encourage older consumers to purchase a limited, and therefore more affordable, long-term care policy, together with an assurance that purchasers could potentially receive additional long-term care services, if needed, through the Medicaid program after their insurance coverage has been exhausted.[15]

What follows is a description of the structural features of each state's program.

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[10] *Private Long-Term Care Insurance: the Medicaid Interaction*, May 2004, AARP Public Policy Institute, available at: http://assets.aarp.org/rgcenter/health/ib68_ltc.pdf.

[11] *Long-Term Care Insurance in 2002*, June 2004, America's Health Insurance Plans, available at: http://www.ahip.org/content/default.aspx?bc=39|341|328|454. This premium is for a policy purchased at age 65, and providing a $150 daily benefit, 5 percent compound inflation protection, four years of coverage and a 90-day elimination period.

[12] *State Cost Containment Initiatives for Long-Term Care Services for Older People*, May 2000, Congressional Research Service, available at: http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL30752.pdf.

[13] For more information on the Robert Wood Johnson Foundation, visit http://www.rwjp.org.

[14] *Overview of the Long-Term Care Partnership Program* (GAO-05-1021R), September 9, 2005, U.S. Government Accountability Office, available at: http://www.gao.gov/new.items/d051021r.pdf.

[15] *The Long-Term Care Partnership Program: Issues and Options*, December 2004, The Brookings Institution Retirement Security Project, available at: https://www.brookings.edu/dybdocroot/views/papers/200412retirement.pdf.

New York's "Total Assets" Model

New York's program requires the purchase of a comprehensive long-term care insurance policy, providing a minimum of three years of nursing home care and six years of home and community-based care or a combination of the two, but offers total asset protection for all of the purchaser's assets at the time of Medicaid eligibility determination. While this model requires a greater initial premium commitment from enrollees than other models (discussed below), New York's approach provides 100 percent protection of assets if participants exhaust their policies and require Medicaid services. The underlying premise of such a "total assets model" is that the period of insurance coverage should be equal to, or exceed, the time during which a person would be penalized by having to pay for long-term care if forced to transfer assets to become Medicaid eligible (when the program in New York began, this period was 30 months).

California and Connecticut's "Dollar-for-Dollar" Models

The programs in California and Connecticut have dollar-for-dollar models in which the dollar amount of protected assets is equivalent to the dollar value of the benefits paid by the long-term care insurance policy. For example, an individual purchasing a long-term care insurance policy with $300,000 total coverage would have $300,000 of assets protected if benefits are exhausted and the policyholder eventually applies for Medicaid assistance.

Indiana's "Hybrid" Model

Although originally adopting a dollar-for-dollar approach structurally similar to the partnership programs in California and Connecticut, in 1998, Indiana adopted a hybrid model allowing purchasers to obtain dollar-for-dollar protection up to a certain state-defined benefit level; all policies with benefits above that threshold amount provide total asset protection for the policyholder.

Features Common to State Programs

A few common features of the partnership policies implemented by these four participant states include incorporation of an inflation protection rider and a non-forfeiture clause. Because states have been targeting citizens in their 50s and 60s, inflation protection (which is typically waived for policyholders purchasing long-term care insurance after a certain age) is essential to maintaining the value of the policy until the policyholder needs the insurance. The period between purchase of the policy and use of its benefits by a policyholder potentially could be decades later.[16] Similarly, non-forfeiture clauses are often a necessary mechanism for protecting the investments of policyholders in the event they can no longer afford premiums. Because individuals pay their insurance premiums for years in advance of needing long-term care services, both California and New York concluded it was important that policyholders have the ability to maintain some portion of their policy benefits if they cannot continue to pay premiums.[17]

Success of Long-Term Care Partnership Programs

The four states using partnership programs vary in how their respective programs protect policyholders' assets, and analysis of such programs' success is complicated because the information collected by the states is not standardized. However, based on the most recently available data compiled by the Government Accountability Office, there are 172,477 active partnership policies insured by a total of 17 participating insurance companies throughout these four states.[18] The percentage of partnership policyholders who were first-time policyholders of long-term care coverage was 94 percent in California, 92 percent in Connecticut, 94 percent in Indiana and 95 percent in New York.[19]

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[16] *Ibid.*
[17] *Ibid.*
[18] *Overview of the Long-Term Care Partnership Program* (GAO-05-1021R), U.S. Government Accountability Office, *supra.*
[19] *Ibid.*

The total number of partnership policies purchased each year has increased significantly since the four states implemented their respective programs. In recent years, however, a decline in the number of policies purchased has been observed. State partnership officials report that such a declilne—or leveling off—is likely reflective of overall trends in the long-term care insurance market, and not specific to the partnership policies.[20]

Data from the partnership states indicate that the program attracts upper middle-class individuals to purchase coverage. In the three states surveying a sample of partnership policyholders—California, Connecticut and Indiana—the majority of policyholders reported that their total assets were greater than $350,000.[21]

Perhaps most importantly, less than 1 percent of active partnership policyholders (1,209 total) are currently accessing their long-term care insurance benefits. Since the programs began, a total of 251 policyholders in the four states have exhausted their long-term care insurance benefits, and just 119 (47 percent) have accessed Medicaid funds.

Still, upon implementation of the partnership programs, several criticisms were initially leveled by both stakeholders and industry analysts alike.[22] Many were troubled that a public assistance program such as Medicaid would endorse private insurance products, which they believed to be beyond the scope and mission of the Medicaid program. Likewise, others were concerned that partnership arrangements would actually increase Medicaid spending, rather than reduce it, if wealthy individuals who would have purchased similar insurance policies anyway participate in the partnership, keep their assets, and are allowed access to Medicaid funds traditionally earmarked for lower-income Americans. Because the partnership policies have thus far been more attractive to higher-income individuals, there is an additional concern that such policies might not be insuring those individuals most likely to otherwise spend down their assets and resources to become Medicaid-eligible.

The Government Accountability Office reports that it is difficult to determine whether and to what extent the Long-Term Care Partnership Program has resulted in cost savings to the Medicaid program, because there is insufficient data to determine if policy purchasers would have accessed Medicaid had they not purchased long-term insurance coverage.

Buoyed by concerns of the morality and wisdom of possibly directing Medicaid funds at upper- and middle-class citizens, the criticisms detailed above initially gave rise to federal opposition to long-term care partnership policies, ultimately resulting in the Omnibus Budget Reconciliation Act of 1993 (OBRA). OBRA amended section 1917 of the Social Security Act—effectively placing restrictions on further attempts to replicate the insurance partnership model—by requiring that any states implementing partnership programs after May 14, 1993, must recover assets from the estates of all persons receiving services under Medicaid upon death.[23] The result of this provision was that, for states wishing to replicate the various asset protection models, the asset protection component of the policies remains in effect, but only while the policyholder is alive.

Nevertheless, interest in the partnership program had grown well beyond the four states initially experimenting with a partnership model to long-term care coverage. At least 16 states (including Florida) have passed legislation to implement a partnership program once restrictions imposed by OBRA were withdrawn or waived.

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[20] *Ibid.*

[21] *Ibid.* In a policyholder survey, California and Connecticut instructed policyholders to exclude the value of homes and cars when reporting assets, while Indiana instructed policyholders to include the value of their homes.

[22] *The Long-Term Care Partnership Program: Issues and Options*, The Brookings Institution Retirement Security Project, *supra.*

[23] Beneficiaries participating in established or approved partnership programs as of May 14, 1993, were exempted from this requirement.

2005 Changes to Florida's Long-Term Care Partnership Program

Chapter 2005-252, L.O.F., amended section 409.905, Florida Statutes, by providing that, for purposes of eligibility determinations for nursing facility services funded by Medicaid, individuals who are beneficiaries of approved long-term care partnership program insurance policies with exhausted policy benefits shall have their total countable assets reduced by $1 for each $1 of benefits paid out under such policy.

The legislation further created section 409.9102, Florida Statutes, directing the Agency for Health Care Administration (AHCA) to establish the Florida Long-term Care Partnership Program (the program), and required the program to do the following:

- Provide incentives for an individual to obtain insurance to cover the costs of long-term care.
- Establish standards, in consultation with the Office of Insurance Regulation (OIR), for designating long-term care insurance policies as approved policies.
- Provide a mechanism to qualify for coverage of the costs of long-term care needs under Medicaid without first being required to substantially exhaust a person's resources, including a reduction of the individual's asset valuation by $1 for each $1 of benefits paid out under the individual's approved long-term care partnership program policy as a determination of Medicaid eligibility.
- Provide and approve long-term care partnership plan information distributed to individuals through insurance companies offering approved partnership policies.
- Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

Additionally, AHCA was directed to develop a plan for the program's implementation, and to present the plan in the form of recommended legislation to the President of the Senate and the Speaker of the House of Representatives prior to the commencement of the 2006 legislative session.

Both the amendments to section 409.905, Florida Statutes, and the creation of section 409.9102, Florida Statutes, were to take effect contingent upon amendment of section 1917(b)(1)(c) of the Social Security Act by the United States Congress to delete the "May 14, 1993" deadline for approval by states of long-term care partnership plans.

The Federal Deficit Reduction Act of 2005

On February 8, 2006, President Bush signed the federal Deficit Reduction Act of 2005 ("the Deficit Reduction Act") into law. Among numerous other changes made to Medicaid and Medicare, the Deficit Reduction Act amends section 1917(b)(1)(C)(ii) of the Social Security Act to allow groups of individuals in states with plan amendments approved after May 14, 1993, to be exempt from estate recovery requirements if the amendment provides for a qualified state long-term care insurance partnership program.

For purposes of the Social Security Act, the term "qualified state long-term care insurance partnership" means a Medicaid state plan amendment providing for the disregard of any assets or resources in the amount equal to the amount of insurance benefit made to or on behalf of an individual who is a beneficiary under an approved long-term care policy (including a certificate issued under a group insurance contract), if the following requirements are met:

- (I) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. In the case of a long-term care insurance policy exchanged for another such policy, this requirement would apply based on the coverage of the first such policy that was exchanged.

- (II) The policy is a qualified long-term care insurance policy (as defined in s. 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the state plan amendment.
- (III) The policy meets the requirements of the long-term care insurance model regulation and the long-term care insurance model Act, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000).
- (IV) If the policy is sold to an individual who:
    - has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;
    - has attained age 61 but has not attained age 76 as of the date of purchase, the policy provides some level of inflation protection; and
    - has attained age 76 as of the date of purchase, the policy may (but is not required to) provide some level of inflation protection;
- (V) The State Medicaid agency under s. 1902(a)(5) of the Social Security Act provides information and technical assistance to the State insurance department on the insurance department's role in assuring that an insurer selling a long-term care insurance policy under the partnership receives training and demonstrates an understanding of the policies and how they relate to other public and private coverage of long-term care.
- (VI) The issuer of the policy provides regular reports including notification regarding when benefits provided under the policy have been paid and the amount of such benefits, notification regarding when the policy otherwise terminates, and such other information appropriate to the administration of such partnerships.
- (VII) The state does not impose any requirement affecting the terms or benefits of such a policy unless the state imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

The Deficit Reduction Act also requires the Secretary of the U.S. Department of Health and Human Services to develop, by January 1, 2007, standards for the uniform reciprocal recognition of long-term care insurance policies among states with qualified state long-term care insurance partnerships, so that benefits paid under such policies will be treated the same by all such states.

The Deficit Reduction Act establishes a National Clearinghouse for Long-Term Care Information. The clearinghouse is responsible for the following:

- Educating consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program, and providing contact information for obtaining state-specific information on long-term care coverage, including eligibility and estate recovery requirements under state Medicaid programs.
- Providing objective information to assist consumers in making decisions about whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care, and providing contact information for additional objective resources on planning for long-term care needs.
- Maintaining a list of states with long-term care insurance partnerships under the Medicaid program that provides reciprocal recognition of long-term care insurance policies issued under such partnerships.

Changes Proposed by the Bill

The bill re-enacts and amends section 409.9102, Florida Statutes, as created by chapter 2005-252, Laws of Florida, and directs AHCA to establish the Florida Long-Term Care Partnership Program, in compliance with the requirements of section 1917(b) of the Social Security Act, and in consultation with OIR and the Department of Children and Family Services (DCF). The bill requires the long-term care program to offer incentives for the purchase of long-term care insurance and to alleviate the financial burden on the state's medical assistance program by encouraging pursuit of private initiatives.

Similarly, the bill requires the long-term care program to disregard the assets of a program participant who subsequently applies for Medicaid assistance for long-term care, in an amount equal to the insurance benefit payments that are made to, or on behalf of, a policyholder of an approved Florida long-term care partnership insurance policy.

Under the bill, AHCA is directed to create, in consultation with OIR and DCF, standards for long-term care partnership plan information to be distributed to individuals through insurance companies offering approved partnership policies. The bill also authorizes AHCA to amend the Medicaid state plan and adopt rules to implement the program.

Consistent with implementation of the Florida Long-Term Care Partnership Program, the bill provides that, when determining eligibility for Medicaid long-term care services for an individual who is the beneficiary of an approved long-term care partnership insurance policy, DCF is to reduce the total countable assets of an individual by an amount equal to the insurance benefits payments made to, or on behalf of, such individual. The bill authorizes DCF to adopt rules to implement this subsection.

Section 627.94075, Florida Statutes, is created by the bill to direct OIR, in consultation with AHCA and DCF, to develop standards for approving long-term care policies and a form or forms to be used by insurers to assist insureds and the program in making a determination of eligible policies. The bill requires insurers to provide information to OIR for determining the number of eligible policies, the amount of benefits paid, and the types of products offered.

The bill provides rulemaking authority for the Financial Services Commission to implement the program, establish standards for the determination of policy eligibility, establish the proper reporting of benefits paid under partnership eligible policies, and adopt certain standardized forms.

Sections 1, 2 and 4 of chapter 2005-252, Laws of Florida, are repealed by the bill to remove contingent effective dates in the chapter law to reflect amendment of the Social Security Act, and to correct the law's effective date.

The Office of Program Policy and Governmental Analysis is directed to prepare a report on the implementation of the Florida Long-Term Care Partnership Program. The report shall include data on the number and value of policies sold and the geographic areas in which the policies were purchased, a demographic description of the policyholders, and other information necessary to evaluate the program. The report shall be provided to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2009.

The provisions of the bill are effective upon becoming law.

C. SECTION DIRECTORY:

Section 1. Reenacts and subsequently amends s. 409.9102, F.S., as created by chapter 2005-252, L.O.F., directing the Agency for Health Care Administration to establish the Florida Long-Term Care Partnership Program, in compliance with s. 1917(b) of the Social Security Act and in consultation with the Office of Insurance Regulation and the Department of Children and Family Services

Section 2. Creates s. 627.94075, F.S., directing OIR to develop certain standards and forms in consultation with AHCA, and granting the Financial Services Commission rulemaking authority to implement the program, establish standards for determination of policy eligibility, establish the proper reporting of benefits paid under partnership eligible policies, and adopt certain standardized forms.

Section 3. Repeals ss. 1 and 2 of chapter 2005-252, L.O.F.

Section 4. Amends s. 4 of Chapter 2005-252, L.O.F., by providing the act is effective upon becoming a law.

Section 5. Requires OPPAGA to prepare a report.

Section 6. Provides the act is effective upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See fiscal comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Because counties participate in the cost of nursing facility care for the Medicaid program, shifting a portion of the cost away from the Medicaid program could result in savings or cost-avoidance to individual counties.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

It is expected that an increased amount of approved long-term care insurance policies will be purchased as a result of this legislation. This renewed interest in long-term care coverage could potentially invigorate the state's insurance industry. However, depending on the criteria ultimately adopted for determination of which policies constitute "approved" Florida Long-Term Care Partnership policies, some insurers offering other long-term care coverage could experience reduced profitability if their particular policies are not approved by the state.

D. FISCAL COMMENTS:

While most of these programs are Medicaid budget-neutral in other states, the full fiscal impact on Florida is unknown at this time. Medicaid may incur expenses related to insurance deductibles and premiums, depending on the final approved structure of the program.

DCF reports that the cost to process applications will increase as a result of this bill, but the number of applications to be processed may go down because of this bill. Therefore, they are unable to determine a fiscal impact at this time.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The municipal/county mandates provision in section 18 of article VII of the Florida Constitution does not appear to be applicable, since the bill does not appear to require counties or municipalities to take action requiring the expenditure of funds, does not appear to reduce the authority that counties or municipalities have to raise revenue in the aggregate, and does not appear to reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Both AHCA and DCF are given rulemaking authority to implement provisions of the Florida Long-Term Care Partnership Program.

Additionally, the Financial Services Commission is granted rulemaking authority to implement the program, establish standards for the determination of policy eligibility, establish the proper reporting of benefits paid under partnership eligible policies, and adopt certain standardized forms.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

At its March 8, 2006 meeting, the Committee on Elder and Long-Term Care adopted a strike-all amendment that made the following changes:

- Provides for AHCA's consultation with OIR and DCF when establishing the Florida Long-Term Care Partnership Program.
- Gives AHCA and DCF rulemaking authority to implement the program.
- Corrects a citation to the federal Social Security Act.
- Creates s. 627.94075, F.S., and directs OIR to develop standards for designation of eligible long-term care policies in consultation with AHCA and DCF.
- Requires insurers to provide certain policy information in an effort to monitor program implementation.
- Provides the Financial Services Commission with rulemaking authority to implement the program, establish standards for the determination of policy eligibility, establish the proper reporting of benefits paid under partnership eligible policies, and adopt certain standardized forms.
- Repeals certain sections of chapter 2005-252, L.O.F., removing contingent effective dates in the chapter law to reflect amendment of the Social Security Act.
- Provides that the bill is effective upon becoming law.

At its March 22, 2006 meeting the Health Care Appropriations Committee adopted an amendment that requires the Office of Program Policy and Governmental Analysis to prepare a report on the implementation of the Florida Long-Term Care Partnership Program. The report shall be provided to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2009.

The committee favorably reported a committee substitute, and this analysis is drafted to the committee substitute.

CHAMBER ACTION

The Health Care Appropriations Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to long-term care coverage; reenacting and amending s. 409.9102, F.S.; directing the Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Family Services, to amend the Medicaid state plan that established the Florida Long-Term Care Partnership Program for purposes of compliance with provisions of the Social Security Act; providing duties of the program; requiring consultation with the Office of Insurance Regulation and the Department of Children and Family Services for the creation of standards for certain information; providing rulemaking authority to the agency for implementation of s. 409.9102, F.S.; providing rulemaking authority to the department regarding determination of eligibility for certain services; creating s. 627.94075, F.S.; requiring the office, in consultation with the agency and the department, to

develop standards for designation of eligible long-term care policies and related forms; providing rulemaking authority to the Financial Services Commission for the implementation of the Long-Term Care Partnership Program; repealing ss. 1 and 2 of ch. 2005-252, Laws of Florida, to delete conflicting provisions relating to determining eligibility for nursing and rehabilitative services and establishing a Long-Term Care Partnership Program that were contingent upon amendment to the Social Security Act; amending s. 4 of ch. 2005-252, Laws of Florida, to delete a contingency in an effective date; requiring the Office of Program Policy Analysis and Government Accountability to submit a report on the implementation of the Florida Long-Term Care Partnership Program to the Governor and Legislature; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 409.9102, Florida Statutes, as created by section 2 of chapter 2005-252, Laws of Florida, is reenacted and amended to read:

(Substantial rewording of section. See s. 409.9102, F.S., for present text.)

409.9102 Florida Long-Term Care Partnership Program.--The Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Family Services, is directed to establish the Florida Long-Term Care Partnership Program, in compliance with the

requirements of s. 1917(b) of the Social Security Act, as amended.

(1) The program shall:

(a) Provide incentives for an individual to obtain or maintain insurance to cover the cost of long-term care.

(b) Provide a mechanism to qualify for coverage of the costs of long-term care needs under Medicaid without first being required to substantially exhaust his or her assets, including a provision for the disregard of any assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under the Florida Long-Term Care Partnership Program.

(c) Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

(2) The Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Family Services, shall create standards for long-term care partnership plan information distributed to individuals through insurance companies offering approved partnership policies.

(3) The Agency for Health Care Administration is authorized to amend the Medicaid state plan and adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section.

(4) The Department of Children and Family Services, when determining eligibility for Medicaid long-term care services for an individual who is the beneficiary of an approved long-term care partnership policy, shall reduce the total countable assets

of the individual by an amount equal to the insurance benefit payments that are made to or on behalf of the individual. The department is authorized to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

Section 2. Section 627.94075, Florida Statutes, is created to read:

627.94075 Florida Long-Term Care Partnership Program.--

(1) The office, in consultation with the Agency for Health Care Administration and the Department of Children and Family Services, is directed to develop standards for the designation of eligible long-term care policies to be issued in accordance with the Florida Long-Term Care Partnership Program as described in s. 409.9102 and a form or forms that shall be used by insurers to assist insureds and the program in making a determination of eligible policies. Insurers, upon request of the office, shall provide information necessary to determine the number of eligible policies, the amount of benefits paid, and the types and kinds of products offered in order to monitor the implementation of the program.

(2) The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement applicable provisions of the Long-Term Care Partnership Program, establish standards for the determination of whether a policy is eligible for the program, establish the proper reporting of benefits paid under partnership-eligible insurance policies, adopt standardized forms to be used by insurers to provide information to insureds and the program regarding the eligibility of the insurer's long-term care policy as a qualifying or nonqualifying policy with

the program, and adopt forms to be filed by insurers to report information requested by the office in connection with the program.

Section 3. Sections 1 and 2 of chapter 2005-252, Laws of Florida, are repealed.

Section 4. Section 4 of chapter 2005-252, Laws of Florida, is amended to read:

Section 4. This act shall take effect upon becoming a law~~, except that the amendments to section 409.905, Florida Statutes, and the newly created section 409.9102, Florida Statutes, provided in this act shall take effect contingent upon amendment to section 1917(b)(1)(c) of the Social Security Act by the United States Congress to delete the "May 14, 1993," deadline for approval by states of long-term care partnership plans~~.

Section 5. The Office of Program Policy Analysis and Government Accountability is directed to prepare a report on the implementation of the Florida Long-Term Care Partnership Program. The report shall include data on the number and value of policies sold and the geographic areas in which the policies were purchased, a demographic description of the policyholders, and other information necessary to evaluate the program. The report shall be provided to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2009.

Section 6. This act shall take effect upon becoming a law.

Amendment to HB 947 CS

Strike all amendment to HB 947 CS by Rep. Legg

- The strike-all directs the Agency for Health Care Administration (AHCA), in consultation with the Office of Insurance Regulation (OIR) and the Department of Children and Family Services (DCF), to establish a qualified state Long-Term Care Partnership in Florida.

- The strike-all changes the name of the program – from the Florida Long-Term Care Partnership Program to "a qualified state Long-Term Care Insurance Partnership in Florida" – for insurers' ease in issuance of policies to be recognized under various state long-term care partnership programs.

- The strike-all provides that, for purposes of determining Medicaid eligibility, assets in an amount equal to the insurance benefit payments made to, or on behalf of, and individual who is a beneficiary under an approved long-term care partnership policy, are to be disregarded.

- The strike-all provides that the Financial Services Commission is to adopt rules to ensure compliance by insurers, in accordance with the Social Security Act and other federal guidelines, including certain reciprocity requirements developed by the Secretary of the U.S. Department of Health and Human Services pursuant to the federal Deficit Reduction Act of 2005.

- The strike-all repeals certain sections of chapter 2005-252, L.O.F., to remove contingent effective dates in the chapter law; this is a necessary technical means of correcting the chapter law to reflect amendment of the Social Security Act.

- Finally, the legislation requires OPPAGA to prepare, by January 31, 2009, a report detailing partnership implementation in the state.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. (for drafter's use only)

Bill No. **947 CS**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health & Families Council

Representative(s) Legg offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 409.9102, Florida Statutes, as created by section 2 of chapter 2005-252, Laws of Florida, is reenacted and amended to read:

(Substantial rewording of section. See s. 409.9102, F.S., for present text.)

409.9102 A qualified state Long-Term Care Insurance Partnership in Florida.--The Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Family Services, is directed to establish a qualified state Long-Term Care Partnership in Florida, in compliance with the requirements of s. 1917(b) of the Social Security Act, as amended.

(1) The program shall:

(a) Provide incentives for an individual to obtain or maintain insurance to cover the cost of long-term care.

(b) Provide a mechanism to qualify for coverage of the costs of long-term care needs under Medicaid without first being

required to substantially exhaust his or her assets, including a provision for the disregard of any assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified state Long-Term Care Partnership in Florida.

(c) Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

(2) The Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Family Services, and in accordance with federal guidelines, shall create standards for long-term care partnership plan information distributed to individuals through insurance companies offering approved partnership policies.

(3) The Agency for Health Care Administration is authorized to amend the Medicaid state plan and adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section.

(4) The Department of Children and Family Services, when determining eligibility for Medicaid long-term care services for an individual who is the beneficiary of an approved long-term care partnership policy, shall reduce the total countable assets of the individual by an amount equal to the insurance benefit payments that are made to or on behalf of the individual. The department is authorized to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

Section 2. Section 627.94075, Florida Statutes, is created to read:

627.94075 A qualified state Long-Term Care Partnership in Florida.-- The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement applicable provisions of a

qualified Long-Term Care Partnership in Florida in accordance with the requirements of s. 1917(b) of the Social Security Act, as amended, and any applicable federal guidelines and such rules necessary to ensure compliance by insurers with the qualified long term care insurance partnership in Florida as provided in s. 409.9102.

Section 3. Sections 1 and 2 of chapter 2005-252, Laws of Florida, are repealed.

Section 4. Section 4 of chapter 2005-252, Laws of Florida, is amended to read:

Section 4. This act shall take effect upon becoming a law~~, except that the amendments to section 409.905, Florida Statutes, and the newly created section 409.9102, Florida Statutes, provided in this act shall take effect contingent upon amendment to section 1917(b)(1)(c) of the Social Security Act by the United States Congress to delete the "May 14, 1993," deadline for approval by states of long term care partnership plans~~.

Section 5. The Office of Program Policy Analysis and Government Accountability is directed to prepare a report on the implementation of a qualified state Long-Term Care Insurance Partnership in Florida. The report shall include data on the number and value of policies sold and the geographic areas in which the policies were purchased, a demographic description of the policyholders, and other information necessary to evaluate the program. The report shall be provided to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2009.

Section 6. This act shall take effect upon becoming a law.

========== T I T L E A M E N D M E N T ==========

Amendment No. (for drafter's use only)

Remove the entire title and insert:

A bill to be entitled

An act relating to long-term care coverage; reenacting and amending s. 409.9102, F.S.; directing the Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Family Services, to amend the Medicaid state plan that established the Florida Long-Term Care Partnership Program for purposes of compliance with provisions of the Social Security Act; providing duties of the program; requiring consultation with the Office of Insurance Regulation and the Department of Children and Family Services for the creation of standards for certain information; providing rulemaking authority to the agency for implementation of s. 409.9102, F.S.; providing rulemaking authority to the department regarding determination of eligibility for certain services; creating s. 627.94075, F.S.; providing rulemaking authority to the Financial Services Commission for the implementation of a qualified state Long-Term Care Partnership in Florida; repealing ss. 1 and 2 of ch. 2005-252, Laws of Florida, to delete conflicting provisions relating to determining eligibility for nursing and rehabilitative services and establishing a Long-Term Care Partnership Program that were contingent upon amendment to the Social Security Act; amending s. 4 of ch. 2005-252, Laws of Florida, to delete a contingency in an effective date; requiring the Office of Program Policy Analysis and Government Accountability to submit a report on the implementation of a qualified state Long-Term Care

Insurance Partnership in Florida to the Governor and Legislature; providing an effective date.